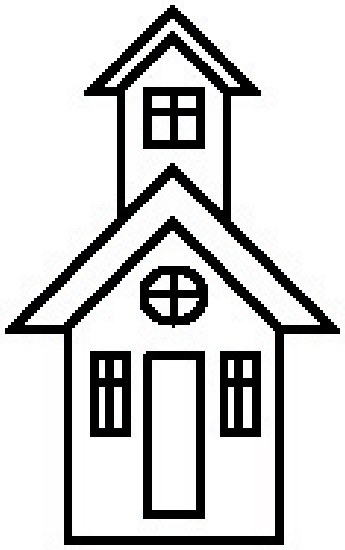

Arkansas Public School Employees

MANAGED BENEFITS
COMPREHENSIVE MAJOR MEDICAL
PREFERRED PROVIDER ORGANIZATION(PPO)
PHARMACY, BEHAVIORAL HEALTH &
LIFE INSURANCE

GROUP BENEFIT SUMMARY PLAN DESCRIPTION

Claims Administrators
Arkanas BlueCross BlueShield
Advanced PCS, CorpHealth, USAble

Plan Administrator:
Employee Benefits Division
P.O. Box 15610
Little Rock, Arkansas 72231

www.accessarkansas.org/dfa/edb
email: askebd@dfa.state.ar.us

Effective:
October 1, 2003

State and Federal laws shall be applied to interpretations of this Summary Plan Description (SPD). If the SPD contains any provision not in conformity with State or Federal Regulation or other applicable laws, the SPD shall not be rendered invalid but shall be constructed and applied as if it where in full compliance with the said State Regulations or any other applicable laws. Should such an occurrence be found; that section of this document shall be re-constructed and distributed to applicable employees with in 90 days.

The intentional use of a pharmacy or health care card beyond valid eligibility may constitute fraud.

Arkansas Public School Employees' Benefit Plan
Summary Plan Description
Table of Contents

Notice of Privacy Practices
From the State of Arkansas
Department of Finance & Administration
Employee Benefit Division
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
Employee Benefits Division (EBD) is responsible for managing health benefits for the State of Arkansas and the Public School Employees. As a group health plan, EBD is required to secure the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information.

"Protected health information," (PHI) means information that is individually identifiable and is protected by privacy regulations. For example, information regarding the health care treatment, payment or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, healthcare claims, specialist referrals, your medical records and other sources. You might provide protected health information by telephone, fax, letter or e-mail. Other sources of protected health information include but are not limited to, healthcare providers, such as **insurance administrators, network providers, claims processors** (hereafter referred to as business partners or affiliates). **When used with health related information, any of the following would be considered protected health information**:

- Marital status
- Name, address, and date of birth
- Information regarding dependents
- Gender
- Social Security Number
- Other similar information that relates to past, present or future medical care

Disclosures of protected health information not requiring authorization
The law allows the use and disclosure of protected health information without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Payment for treatment
- Business planning and development
- Claims administration
- Coordination of benefits
- Insurance underwriting
- Enrollment into the group health plan
- Premium billing
- Eligibility for coverage issues
- Payment of claims
- Complaint review
- Appeals review
- Regulatory review and legal compliance

Uses and disclosures for treatment: Your protected health information will be obtained from or disclosed to health care providers involved in your, or your dependents treatment.

Uses and disclosures for payment: Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations: Your protected health information will be used and disclosed for plan operations including but not limited to underwriting, premium rating, auditing, and business planning. In order to ensure the privacy of your protected health information, EBD has developed privacy policies and procedures. During the normal course of business, EBD may share this information with its business partners or affiliates that have signed a contract specifying their compliance with EBD's privacy policies.

NOTE: Only the minimum necessary amount of information to complete the tasks listed below will be disclosed.

Disclosures of personal health information requiring authorization
In all situations, other than outlined above, EBD will ask for your authorization to use or disclose your protected health information. EBD will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

- Usually, only the person to whom the protected health information pertains may make authorization.
- In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
- Any 3rd party acting as your advocate (for example, a family member, your employer or your elected official) would require an authorization

Forms
Forms may be obtained from EBD, Forms are:

- Authorization for Release of Protected Health Information
- Revoking Authorization for Release of Protected Health Information

Your Rights

- You have the right to review and copy your protected health information maintained by EBD. If you require a copy of PHI the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
- You can request a copy of the Notice of Privacy Practices from EBD.
- You have the right to request an accounting, or list, of non-routine disclosures of your protected health information by EBD as of the compliance date. This request must be made in writing.
- You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communications regarding your protected health information from EBD be made at a certain time or location. This request must be in writing and EBD reserves the right to refuse the restriction.
- You have the right to receive confidential communication of PHI at alternate locations and by alternate means.

If you believe your privacy rights have been violated, you have the right to register a complaint with EBD's Privacy Officer:

EBD Privacy Officer
P.O. Box 15610
Little Rock, AR 72231
(501) 682-9656

Or you can send your complaint to the Secretary of Health and Human Services:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

To e-mail the HHS Secretary or other Department officials, send your message to: HHS.Mail@hhs.gov.

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Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint.

Changes to Privacy Practices
If EBD changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. Additional information, additional examples and up-to-date privacy notices are maintained on the EBD website at http://www.accessarkansas.org/dfa/ebd.

This notice became effective on April 14, 2003.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under Arkansas State and Public School Employee Life and Health Insurance Benefits Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description.

The Plan Administrator is: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610, (501) 682-9656, Toll-Free (877) 815-1017. Employee Benefits Division is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child is no longer eligible for coverage under the Plan as a "dependent child."

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Arkansas State Agencies or the Arkansas Public School System and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits Division has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Employee Benefits Division of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Employee Benefits Division. The Plan requires you to notify Employee Benefits Division within 60 days after the qualifying event occurs. You must send this notice to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610.

Once Employee Benefits Division receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date the Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify Employee Benefits Division in a timely fashion, you and your entire family can received up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Employee Benefits Division is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610. A copy of the Determination letter must accompany the notification.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that Employee Benefits Division is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Employee Benefits Division, 1515 West Seventh Street, Suite 300, P. O. Box 15610, Little Rock, Arkansas 72231-5610. Documentation of the qualifying event must accompany the notification.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Employee Benefits Division, or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep Employee Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Employee Benefits Division.

ARKANSAS PUBLIC SCHOOL EMPLOYEE
PPO SCHEDULE OF BENEFITS

	In-Network	Out-of-Network
Deductible(Annual)		
Individual	$500	$1,500
Family	$1000	$3,000
Co-Insurance (what you pay)	20% After Deductible	40% After Deductible
Annual Co-Insurance Limit		
Individual	$3,000	$8,000
Family (Two individuals deductibles must be satisfied)	$6,000	$16,000
Lifetime Maximum	No Maximum	$1,000,000
Preventive Care Services		
Well Baby/Child Care	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Children's Immunizations	0% Co-Insurance	0% Co-Insurance
Routine Gynecological Visits and Mammography	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Physician Services	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Outpatient Services	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Inpatient Hospital	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Skilled Nursing Facility or Rehab 60 days per Benefit Year limit	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Emergency Care		
Illness and Accident	20% Co-Insurance after Deductible is met	20% Co-Insurance after Deductible is met

	In-Network	Out-of-Network
Maternity Services		
Physician Services	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Hospital Services	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Transplants	**Must be approved**	**Must be approved**
(Up to $10,000 for travel and lodging when in conjunction with transplant services)	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Durable Medical Equipment, $10,000 max per Benefit Year.	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Prosthetics Devices, $15,000 max per Benefit Year	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
TMJ $500 lifetime max	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Speech, Occupational And Physical Therapy, Cardiac Rehabilitation and Chiropractic Services		
Maximum of 60 visits combined therapies per Benefit Year	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Ambulance (Land or Air) $1,000 max per year (limit does not include life saving medications	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Home Nurse Visits 120 visits per Benefit Year	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Home Infusion IV Drugs / Solutions / Supplies	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met
Ostomoy Supplies (Benefit is for a 3 month supply)	20% Co-Insurance after Deductible is met	40% Co-Insurance after Deductible is met

HOSPITAL PRE-ADMISSION NOTIFICATION

Please call 1-800-451-7302 if you are admitted to a Hospital outside the State of Arkansas.

IMPORTANT NOTICE

If you use a Hospital/Physician who is a Preferred Provider, such Hospital/Physician has agreed to accept your plan's payment for covered services as payment in full, except for Deductible and Appropriate Co-Insurance, if applicable.

If you use a hospital/physician who is a Non-Preferred Provider, such hospital/physician is free to bill you charges for covered services in excess of your plan's payment.

Before receiving services from any Hospital/Physician, it is your responsibility to verify that you are using a network provider. Otherwise, the financial burden falls to you.

PLAN ADMINISTRATION

This document is a summary description of Arkansas Public School Employees' Insurance program.

Plan Administrator. The Employee Benefit Division for the State of Arkansas Department of Finance and Administration ("EBD") has established and maintains the Arkansas Public School Employees' Insurance Plan (the "Plan") for active and retired Arkansas Public School employees and their eligible dependents. The EBD serves as Plan Administrator and administers the Plan in accordance with applicable law and actively promotes the Plan to Arkansas Public School Employees.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

EBD reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Amendments to the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, copayment, exclusions, limitations, definitions, eligibility and the like. If the Plan is amended, EBD will give thirty (30) days written notice to your Employer and the amendment will go into effect on the date fixed in the notice.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force.

Claims Administrator. Arkansas Blue Cross and Blue Shield serves as the Claims Administrators for this Plan. As the Claims Administrator, Arkansas Blue Cross and Blue Shield (the Company) has authority and full discretion to determine all questions arising in connection with coverage under the Plan, including interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of Arkansas Blue Cross and Blue Shield acting on behalf of the Plan are subject to the Complaint and Appeal Process set out in this Summary Plan Description (SPD).

ARTICLE I. STATEMENT OF COVERAGE

.A. This coverage is most effective and advantageous when the services of Preferred Providers (Physicians or Hospitals) are used. Reimbursement for services by Non-Preferred Providers generally will be less than payment for the same services when provided by a Preferred Provider and could result in substantial additional out-of-pocket expense. Please consult the Provider Directory distributed at the Enrollment Meetings or consult the Claims Administrator's on-line provider directory at www.arkansasbluecross.com.

B. Preferred Providers are Physicians or Hospitals who are paid directly by the Claims Administrator and have agreed to accept the Plan's payment for covered services as payment in full except for your Deductible and Appropriate Co-Insurance, if applicable. You are responsible for all balances when services are rendered by Physicians or Hospitals who are not a Preferred Provider. The determination of whether a Physician or Hospital is a Preferred Provider, or Non-Preferred Provider is the responsibility of the Claims Administrator.

C. The decision about whether to use a Preferred Provider is the sole responsibility of the Covered Person. Preferred Providers are not employees or agents of the Claims Administrator or EBD. Neither EBD nor the Claims Administrator make any representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

D. The effective date of coverage is indicated on your Identification Card summary.

E. Continuance of coverage under the Plan shall be contingent upon receipt of insurance premiums remitted in advance by your Employer.

F. After you are enrolled as a Covered Person, the Claims Administrator will prepare Identification Cards and mail them directly to your home. If you have family coverage you will receive two Identification Cards, one for you and one for your Spouse or dependent. All eligible dependents will be listed on the Identification Card. Additional cards can be requested by calling the Claims Administrator, Customer Service at 1800-482-8416 or 501-378-2437.

You should carry your Identification Card with you at all times because it eliminates red tape and helps you when filing claims. When you or your dependents are hospitalized, your card should be presented to the Hospital admitting desk. The Hospital will then credit your bill with the benefits available under the Plan. You should also present your card to your Physician when you first request his services. Payment will be made to you or your Physician according to the benefits of the Plan.

G. Your Employer is recognized as your agent for all dealings with respect to:

1. remitting insurance premium to the EBD;
2. changes in coverage status (from individual to family or from family to individual);
3. submitting enrollment applications to EBD;
4. all communications and notices from EBD or the Claims Administrator.

EBD and Claims Administrator will consider you to have received any notice mailed to you at the current address on EBD's database.

ARTICLE II. DEFINITIONS

A. **Accidental Injury** is defined as bodily injury (other than intentionally self-inflicted injury) sustained by a Covered Person while the insurance is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity.

B. **Ambulance Service** means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the Specific Plan limitation applied to ambulance benefits per Benefit Year.

C. **Annual Co-Insurance Limit** means the total Co-Insurance payment a Covered Person is required to pay in a Benefit Year.

D. **Appropriate Co-Insurance** - see "Co-Insurance" and ARTICLE XI.

E. **Behavioral Health Care Provider** means a psychiatrist, a psychologist, an inpatient or outpatient hospital service for mental health or substance abuse, a mental health or substance abuse facility of any kind, or any other health care professional or counselor specializing or engaging primarily in offering mental health or substance abuse treatment or counseling. The term does not include family practitioners, general practitioners, internal medicine practitioners or pediatricians who do not specialize or concentrate their practice in mental health or substance abuse treatment. Behavioral and Substance Abuse Care is covered by CorpHealth and is separate from the coverage provided by Blue Cross and Blue Shield.

F. **Benefit Year** means a calendar Benefit Year (October 1 through September 30).

G. **Charge**, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic reasonable Charge. However, this Charge may vary, given the facts of the case and the opinion of the Claims Administrator's Medical Director.

At the option of the Claims Administrator, charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XIV. G. dealing with Out of Arkansas Claims. See ARTICLE IX.T.5. with respect to Charge for transplants. Please note that all benefits under the Plan are subject to and shall be paid only by reference to the Charge as determined in the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care provider may bill for a given service, the benefits under the Plan will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Co-Insurance or non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield allowance in addition to your Deductible, Co-Insurance and non-covered services.

H. **Chemotherapy** means chemotherapy for the treatment of a malignant disease by chemical agents that affect the causative organism unfavorably. High Dose Chemotherapy is chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the

addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient who received this high dose chemotherapy, to prevent life-threatening complications of the chemotherapy on the patient's own proginator blood cells.

I. **Child** means an Employee's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Employee for adoption. "Child" also means a Child for whom the Employee or the Spouse must provide medical support under a qualified medical support order or for whom the Employee has been court appointed the legal guardian.

J. **Claims Administrator** means Arkansas Blue Cross and Blue Shield, A Mutual Insurance Claims Administrator. Arkansas Blue Cross administers claims in connection with medical services for physical illnesses and injuries. Prescription drug claims and Mental Health Service claims are administered by other claims administrators under contract with EBD.

K. **Co-Insurance** means the obligation of the Plan to pay a Charge. The Plan's Co-Insurance is expressed as a reciprocal of the percentage set forth in the Schedule of Benefits. The Covered Person's Co-Insurance is the reciprocal percentage to the Plan's. The Schedule of Benefits sets forth the Covered Person's Appropriate Co-Insurance for services or supplies received from a Preferred Provider and the Covered Person's Appropriate Co-Insurance for services and supplies from Non-Preferred Providers.

L. **Cosmetic Services** means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include services in connection with a mastectomy resulting from cancer, (a) reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce a symmetrical appearance. The following procedures performed on a child under 12 years of age are not considered Cosmetic Services: correction of a cleft palate or hair lip, removal of a port-wine stain on the face, correction of a congenital abnormality. Note. This does not include a dental abnormality.

M **Coverage Policy** means a statement developed by the Claims Administrator that sets forth the medical criteria for coverage under an Arkansas Blue Cross and Blue Shield SPD. Some limitations of benefits related to coverage of a drug, treatment, service, equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from the Plan, at no cost, upon request, or a Coverage Policy can be reviewed on the Claims Administrator's Website at **www.arkansasbluecross.com**.

N. **Covered Person** means an Employee and Dependents, if any, for whom premiums have been paid. If both an individual and the individual's Spouse are insured as Employees, their eligible Children may be insured as Dependents of only one of them.

O. **Custodial Care** means care rendered to a Covered Person (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who

is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. Custodial Care is not precluded by the fact that a Covered Person is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the Covered Person's condition, or provide for the Covered Person's comfort, or ensure the manageability of the Covered Person. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N. or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a skilled nursing facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Covered Person; it only means that it is the kind of care that is not covered under the Plan.

P. **Deductible** means the amount shown in the Schedule of Benefits as covered medical expenses to be incurred in each Benefit Year by you or any eligible dependents, if any. If more than two eligible Covered Persons on one contract incur covered medical service expenses that exceed the medical Deductible amounts during one Benefit Year no additional Deductible will be assessed. A benefit year begins October 1st and ends September 30th. New enrollees will be required to meet deductables on his/her effective date. There is no deductable carry over.

Q. **Dental Care** means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural, and shall include any Hospital services and administration of anesthetic in connection with any of the foregoing.

R. **Dependent** means any member of an Employee's family who meets the eligibility requirements of ARTICLE III. who is enrolled in the Plan and premium has been paid.

S. **Dependent Insurance** means insurance on the dependent of an Employee.

T. **Diabetes Self-Management Training** means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purpose of which is weight reduction. The training must enable diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

U. **Drug Overdose** shall mean the excessive ingestion of any substance recognized in an official pharmacopoeia or any substance which is likely to cause addiction or habituation or any substance which in any manner changes, distorts or alters the auditory, visual or mental processes, if treatment for such is received in an Emergency setting from any medical facility or Physician.

V. **Durable Medical Equipment (DME)** means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use

in the home.

W. **EBD** means the Arkansas Department of Finance and Administration, Employee Benefits Division.

X. **Effective Date** means the date a Covered Person's coverage under the Plan commences in accordance with ARTICLE IV., below.

Y. **Emergency** means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health to believe that his condition, sickness, or injury is of such a nature that failure to get immediate medical attention could result in: placing the patient's health in serious jeopardy, serious impairment to body functions, or serious dysfunction of any body part.

Z. **Employee** means an employee of any Arkansas Public Schools and Co-ops, who meet all applicable eligibility requirements of ARTICLE III. Eligibility for Coverage, and who's Personal Insurance is in effect in accordance with the requirements of the Plan.

AA. **Employer** means any Arkansas Public Schools and Co-ops.

BB. **Full-Time Employee** means a full-time, active employee with any Arkansas Public Schools and Co-ops:

1. On a permanent and active basis;

2. For compensation;

CC. **Group** means Arkansas Department of Finance and Administration, Employee Benefits Division when used herein.

DD. **Hospice Care** means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient and home-like inpatient care for the terminally ill patient and family. Hospice Care provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

EE **Hospital** means an acute general care Hospital and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of the Claims Administrator: Hospitals owned or operated by state or federal agencies, convalescent homes or hospitals, homes for the aged, sanitariums, psychiatric hospitals, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

FF. **Late Enrollee** means a person who submits an application for coverage other than during:

1. the first period in which the person is eligible to enroll in the Plan; or
2. a Special Enrollment Period.

GG. **Lifetime Maximum Benefit.** The maximum Out-of-Network lifetime benefit is $1,000,000 for each Covered Person.

HH. **Low Protein Modified Food Products** means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of phenylketonuria.

II. **Maintenance Therapy** means generally, any therapy lasting over sixty (60) days. There must be an expectation based upon a reasonable degree of medical probability that treatment will result in significant measurable improvement in the condition in a reasonable, predictable period of time for the treatment not to be considered maintenance therapy.

JJ. **Maternity Care and Obstetrical Care** means any services related to your care while you are pregnant that would not be required if you were not in a pregnant state. These services include, but are not limited to, a scheduled c-section for any reason including a previous c-section delivery, vaginal delivery, antepartum and postpartum care, services related to the management of a difficult pregnancy, services related to false labor, occasional spotting, physician prescribed rest during the pregnancy, morning sickness, premature rupture of membranes, pre-term birth, pre-term labor, cephalopelvic disproportion and a breech presentation.

Services necessary to promote the fetus' health or life would also be considered Maternity Care. These services include, but are not limited to, ultrasounds, amniocentesis, biophysical profiles, fetal monitoring and hospitalization to postpone delivery until the fetus is further developed.

KK. **Medical Food** means a food that is intended for the dietary treatment of phenylketonuria for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

LL. **Medically Necessary/Medical Necessity** means services and/or supplies provided to treat a Covered Person's illness or injury and which, as determined by the Claims Administrator's Medical Director, are (1) consistent with the symptoms or diagnosis and treatment of the Covered Person's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Person, his or her physician or provider; and (4) the most appropriate supply or level of service which can be safely provided to the Covered Person. When specifically applied to an inpatient, it further means that the Covered Person's medical symptoms or conditions require that the diagnosis or treatment cannot be safely provided to the Covered Person as an outpatient.

MM. **Mental Health Services** means the provision of Medically Necessary services and supplies for the treatment of Psychiatric Conditions. Mental Health Services rendered by a Behavioral Health Care Provider are not described in this section of this SPD. See ARTICLE XII., Section MM and the CorpHealth section of this SPD.

NN. **Non-Preferred Provider/Out of Network** means a Provider who has declined to sign a contract with Claims Administrator to provide services covered by the Plan to Covered Persons. Non-Preferred Providers are free to bill you Charges for covered services, which are in excess of the Plan's payment.

OO. **Non-Diseased Tooth** means a tooth that is whole or properly restored, and is free of decay and/or periodontal conditions.

PP. **Nursing Home** means an institution licensed as such by the appropriate state agency. It must:

1. provide convalescent care;
2. be staffed by a licensed nurse under the supervision of a licensed Doctor of Medicine (M.D.);

3. be a member of an association of Nursing Homes, which is on an approved list kept by the Claims Administrator at its home office.

QQ. **Outpatient Psychiatric Center** means a facility licensed as such. Services rendered in an Outpatient Psychiatric Center are not described in this section of this SPD. See ARTICLE XII., Section MM.

RR. **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such.

SS. **Period of Creditable Coverage** means the period of time a Covered Person was covered by a health Plan or insurance contract defined as creditable coverage in the provisions of the Health Insurance Portability and Accountability Act of 1996. Common health Plans and insurance contracts providing creditable coverage including Employer Group Health Insurance, Individual Comprehensive Health Insurance, Medicare, Medicaid, Tri-Care and a State Health Benefits Risk Pool. Any continuous sixty-three (63) day period during which the Covered Person was not covered will start a new Period of Creditable Coverage.

TT. **Personal Insurance** means insurance on an Employee.

UU. **Physician** means a Doctor of Medicine (M.D.) and a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place service is rendered. Physician also means a licensed Doctor of Podiatry (D.P.M.), a licensed Chiropractor (D.C.), a licensed Psychologist (Ph.D.) a licensed Oral Surgeon (D.D.S.) and a licensed Optometrist (O.D.).

VV. **Physician Service** means such services as are rendered by a licensed Physician within the scope of his license.

WW. **Plan** means the employee health benefit Plan established by the Arkansas Department of Finance and Administration, Employee Benefits Division. The terms of the Plan are summarized in this SPD and in other summary plan descriptions issued at the direction of the Plan Administrator.

XX **Plan Administrator** means the Employee Benefits Division for the Arkansas State and Public School Employees and Co-ops of Arkansas, Department of Finance and Administration.

YY. **Plan Year** means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of the Group Policy.

ZZ. **Preferred Provider** means a provider of service who has signed a Contract with Claims Administrator to provide the services covered by the Plan and which has agreed with the Claims Administrator, directly or indirectly, to participate in the Preferred Provider Organization.

AAA. **Provider** means a Hospital or a Physician. Provider also means a Certified Registered Nurse Anesthetist. Provider also includes any other type of health care Provider which the Claims Administrator, in its sole discretion, approves for reimbursement for services rendered.

BBB. **Prosthetic Appliances** means appliances that replace all or part of a body organ (including contiguous tissue), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

CCC. **Psychiatric Conditions** means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and Psychiatric Conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.) Mental Health Services for the treatment of Psychiatric Conditions rendered by a Behavioral Health Care Provider are not covered in this section of this SPD. See ARTICLE XII., Section MM and the Behavioral Health Portion of this SPD.

DDD. **Retransplantation** means a second transplant performed within sixty (60) days of the failure of an initial transplant.

EEE. **Routine Prenatal Care** means outpatient antepartum care and laboratory testing that has been approved as routine based on the criteria established by the Claims Administrator.

FFF. **Screening Test** means a test used to detect an undiagnosed disease in an individual who has neither symptoms, findings nor any past history of the specific disease for which the screening test is being performed.

GGG. **Skilled Nursing Facility** means a facility, which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

HHH. **Special Enrollment Period** means a thirty (30) day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Waiting Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. After the Termination of Another Health Plan: A Special Enrollment Period occurs (1) after an employee's or dependent's coverage under another health Plan terminated as a result of loss of eligibility or (2) after the employer providing such other health Plan terminated its contributions. In order for the Special Enrollment Period to apply, the employee must have stated in writing, at the time coverage under the Plan was first offered, that the employee or dependent(s) were declining coverage because of coverage under such other health Plan.

2. After the Addition of a Dependent. A Special Enrollment Period occurs for an employee, employee's Spouse or employee's new dependent Child (1) after the employee marries; (2) after an Employee's Child is born or (3) an employee adopts a Child or has a Child placed with the employee for adoption.

III. **Spouse** means a member of the opposite sex who is the husband or wife of an Employee as a result of a marriage that is legally recognized in the state of Arkansas.

JJJ. **Step Child** means a natural or adopted Child of the Spouse of the Employee provided:

1. such Child lives with the Employee in a parent-Child relationship; and

2. the Employee has a legal right to claim and does claim such Child as a Dependent on his federal income tax form.

KKK. **The Masculine Gender** when used herein shall include the feminine gender.

LLL. Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The commencement-date and end-date of the Transplant Global Period vary, depending upon the type of transplant involved.

MMM. **Waiting Period** means the time beginning with the employee's most recent date of continuous employment with the Employer and ending on the date he is eligible for coverage. The Employer establishes the Waiting Period but for purposes of coverage or eligibility determinations under the Plan, the Waiting Period shall be such period as is reflected in the enrollment records of the Claims Administrator.

NNN. **We, Our and Us** mean the Claims and Plan Administrator.

OOO. **You and Your** mean a Covered Person.

ARTICLE III. ELIGIBILITY FOR COVERAGE

Eligibility for coverage is determined according to these guidelines.

A. **Personal Insurance.** To be eligible for Personal Insurance an Employee must:

1. be a Full-Time Employee of an Arkansas Public School or Co-ops.
2. be an eligible retiree under the Arkansas Public Employees' Retirement System, the Arkansas Teacher Retirement System, Judicial Retirement System, or Arkansas State Highway Retirement System.

B. **Dependent Insurance.** Eligible Dependents are the Employee's:

1. Spouse;
2. unmarried Children, if, but only if, they fall into one or more of the following categories:
   a. a Child less than age 19 and living in the home;
   b. a Child who is enrolled and regularly attending on-campus classes as a full-time student at an accredited college or university, under age 27 and who is financially dependent on the Employee. Employee Benefits Division has full authority to make the determination about which schools qualify under this provision.
   c. a Child of any age who is medically certified as totally disabled due to mental or physical incapacity and chiefly dependent on the Employee for financial support, provided the requirements of Section D. below, are met.

C. **Employee must be Covered.** In order for an Employee's Dependent to be eligible for coverage, the Employee must be eligible for and have coverage.

D. **Proof of Mental or Physical Incapacity**. In order for dependent coverage to be provided due to mental or physical incapacity, proof of the Child's dependency and incapacity must be furnished to the Claims Administrator prior to the Child's attainment of the applicable limiting age referenced in sections B.2.a. and B.2.b, above. Subsequent evaluation for continued incapacity and dependency may be required by the Plan, but not more frequently than once per Benefit Year. Newly eligible Employees may enroll an incapacitated dependent

child provided the disability commenced before the limiting age, and the child has been continuously covered under a health benefit plan as a Dependent of the Employee since before attaining the limiting age. The Claims Administrator's decision may be appealed to EBD. EBD's determination of eligibility shall be conclusive.

E. **Student Coverage Verification and Termination:**

1. When a Dependent is eligible for coverage on a student basis as set forth in Section B.2.b, above, coverage is conditioned upon continued student status and documentation of such status as outlined in Section B.2.b.

2. The Employee and Dependent are each responsible to notify EBD of a change in student status of a Child; however, the EBD may request verification of student status each academic term.

3. Both the Employee and the Dependent are obligated to respond promptly and fully to any EBD student verification request, and Employee and Dependent hereby authorize any school office or representative to release to the EBD all information the EBD may request concerning the Dependent's enrollment, academic or disciplinary record, attendance record and continued student status.

4. If the EBD is unable to verify continued student status as required by Section B.2.b hereof, or if either the Employee or Dependent fails to promptly respond to inquiries from EBD, or fails to authorize release of any information to EBD, the Dependent's coverage may be terminated by EBD, regardless of the Dependent's actual student status, upon 15 day's written notice from EBD.

5. If a Dependent (19 or older) covered due to student status ceases to be enrolled and regularly attending on-campus classes, all coverage under the Plan shall terminate at the end of the academic term of the school the Dependent was attending in which any of the following occur: (a) the Dependent formally withdraws from school enrollment; or (b) the Dependent notifies any school office or official that the Dependent intends to withdraw or cease attendance; or (c) the Dependent or any parent, guardian or representative of the Dependent is notified by the school that enrollment as a student will be terminated, suspended or placed on administrative hold or probation; or (d) the Dependent leaves or abandons school or fails to meet minimal school attendance standards or testing requirements for continued enrollment as a full-time student. However, in the event the Dependent graduates from secondary school and has been accepted at an institution of higher learning, student coverage shall terminate on September 30 of the year of such secondary school graduation if the Dependent fails to enroll in the institution of higher learning by that date.

6. If a question is raised as to a Dependent's student status, EBD may withhold processing or payment of any claim, pending the outcome of EBD's investigation and verification of student status. Claims for services received after a Dependent ceases to be enrolled and regularly attending on-campus classes under any of the conditions outlined in paragraph (5) above, are not covered and shall be denied by the Claims Administrator, regardless of when EBD learns of the termination of student status. If the Claims Administrator has processed or paid any claims before learning that student status terminated, Employee and Dependent agree to cooperate fully with the Claims Administrator and EBD in recovering any such payments from providers, and, if such amounts are not promptly refunded to the Claims Administrator and

EBD, Employee and Dependent agree to reimburse the Plan the full amount of any such payments.

F. **Medical Support Orders.** Dependent Insurance shall be extended, on the same basis as to other Children, to a Child for whom the Employee or the Employee's Spouse must provide medical support under a qualified medical support order regardless of whether the Child resides with the Employee or is claimed by the Employee as an exemption for federal income tax purposes.

ARTICLE IV. EFFECTIVE DATE OF COVERAGE

A. **Application and Effective Date**. In order for an Employee's coverage to take effect, the Employee must submit a written application for coverage for the Employee and any Dependents to the School District. The Effective Date(s) of coverage shall be the date indicated on the ID Card attachment.

B. **Employees and Dependents on Contract Effective Date.** Coverage under the Plan shall become effective on the Plan Effective Date for all Employees and Dependents for whom an enrollment application is completed and appropriate contribution is paid to EBD during the Initial Annual Enrollment Period prior to the Plan Effective Date. This includes any eligible employee or dependent who is confined in a Hospital.

C. **Initial Enrollment for New Employees.** If EBD receives the Employee's enrollment application within thrity (30) days of the Employee's date of employment, the Employee's coverage will become effective on the first day of the month following thirty (30) days of employment.

D. **Coverage in the Case of Late Enrollment.** If an Employee or an Employee's Dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible for coverage, the Employee or Dependent can not subsequently obtain coverage, except during an Annual Enrollment Period or during a Special Enrollment Period.

E. **Annual Enrollment Period.** Annually, during the month of August, Employees who are eligible for coverage may enroll in the Plan. During the Annual Enrollment Period, employees covered in the Plan may change their coverage, and that of their Dependents, to any one of the carriers providing a group health plan under the Plan. Enrollments and coverage changes made during the Annual Enrollment Period become effective on the first day of October.

F. **Initial Enrollment Period for Existing Dependents.** If the Employee has eligible Dependents on the date his coverage begins, the Employee's Dependents' coverage will begin on the Employee's Effective Date if:

1. The Employee submits a written application for Dependents' Coverage within 30 days of the Employee's Effective Date; and

2. The appropriate fee is paid on a timely basis.

G. **Initial Enrollment Period for Newly Acquired Dependents.** If an Employee acquires new eligible Dependents after the date the Employee's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:

1. **Spouse**. When an Employee marries and wishes to have his or her Spouse covered,

the Employee shall submit an application or change form within 30 days of the date of marriage. The Effective Date will be the first of the month following the date of marriage. If the Employee submits the application or change form after the 30-day period, coverage for the Employee's Spouse will become effective in accordance with the provisions for Late Enrollees. See ARTICLE IV. D., above.

2. **Newborn Children**. Coverage for an Employee's newborn Child shall become effective as of the date of birth if the Employee gives EBD notice of the Child by submitting an application or change form to EBD for the Child within thirty (30) days of the Child's date of birth, if the Employee has coverage for the Employee only or Employee and Spouse. If the Employee has coverage for Employee and Children or Employee and Family at the time the Child is born, the Employee must give EBD notice within ninety (90) days of the Child's birth. If the Employee submits the application or change form after the applicable thirty (30) day or ninety (90)day time period, coverage for the Employee's newborn Child will become effective in accordance with the provisions for Late Enrollees. See ARTICLE IV. D., above.

3. **Court Ordered Coverage for a Child.** If a court has ordered an Employee or the Employee's Spouse to provide coverage for a Child, coverage will be effective on the first day of the month following the date EBD receives written notification and satisfactory proof of the court order. If the Employee fails to apply to obtain coverage for such Child, EBD shall enroll the Child on the first day of the month following EBD's receipt of a written application of a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.

4. **Newly Adopted Children**: Subject to payment of all applicable premiums, coverage for a Child placed with an Employee for adoption or for whom the Employee has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided an application for the Child's coverage is submitted to EBD within sixty (60) days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the application for coverage is submitted to EBD within 60 days of the Child's birth. If the Employee submits the application or change form after such sixty (60) day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollees. See ARTICLE IV. D., above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

5. **Other Dependents**. Written request for enrollment must be received by Plan Administrator within thirty (30) days of the date that any other dependent first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received by EBD. If the Employee submits the application or change form after the thirty (30) day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollees. See ARTICLE IV. D. above.

H. **Employee's Effective Date Controls.** In no event will a Dependent's coverage become effective prior to the Dependent's Employee's Effective Date.

I. **Special Enrollment Period** is the 30 day period during which time an Employee or

Employee's Dependent may enroll in the Plan, after his or her initial Waiting Period or Annual Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. **After the Termination of Another Health Plan.** A Special Enrollment Period occurs (1) after an employee's or dependent's coverage under another health plan terminated as a result of loss of eligibility, or (2) after the employer providing such other health plan terminated its contributions. In order for the Special Enrollment Period to apply, the employee must have stated in writing, at the time coverage under the Plan was first offered, that the employee or dependent(s) were declining coverage because of coverage under such other health plan. The Effective Date of Coverage will be the first day of the month following receipt of the application for coverage.

2. **After the Addition of a Dependent.** A Special Enrollment Period occurs for an employee, employee's Spouse or employee's child (1) after the employee marries, (2) after an employee's child is born, or (3) after an employee adopts a child or has a child placed with the employee for adoption. The Effective Date of Coverage shall be governed by the provisions of the Plan concerning addition of a Spouse, a newborn Child or an adopted Child, as applicable.

ARTICLE V. TERMINATION OF COVERAGE

A. **Termination Date:**

1. **Events Triggering Termination:**

Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Covered Person shall terminate if any of the following events occur with respect to such Covered Person:

a. the Employee or Covered Person dies; or

b. the Covered Person ceases to be eligible as an Employee or Dependent for any reason; or

c. the Covered Person is a Dependent Spouse that becomes legally separated from the Employee; or

d. the Plan terminates; or

e. the Covered Person's coverage is terminated "for cause," as hereinafter provided.

2. **Effective date of Termination:**

The effective date of termination of coverage may be specified for certain conditions, as described in various other places throughout this document. For events specified in ARTICLE V.A.1 of this document, the effective date of termination shall be as follows:

a. the effective date of termination for any event listed in ARTICLE V.A.1.a, e, or f shall be 12:00 midnight, Central Standard Time, on the day the event occurs.

b. the effective date of termination for any event listed in ARTICLE V.A.1.b or c

shall be 12:00 midnight, Central Standard Time on the last day of the Contract Month the event occurs.

c. the effective date of termination for any event listed in ARTICLE V.A.1.d shall be the last day of the applicable premium period for which premium was paid.

d. the effective date of termination for any event listed in ARTICLE V.A.1.e shall be the date as specified in ARTICLE V. B., below.

B. **Termination of a Covered Person's Coverage For Cause:**

1. **Concealment, Misrepresentation or Fraud.** The Plan may terminate coverage of a Covered Person subject to a fifteen (15) days' written notice and appeals rights as outlined in Section B.3., below, for:

   a. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage for the Covered Person or an Eligible Dependent; or

   b. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

   For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided and (ii) the Plan would not have provided coverage, or would not have paid a claim in the manner it was paid had the Plan or Claims Administrator known the facts concealed or misrepresented.

2. **Other Causes.** Coverage of a Covered Person under the Plan may be terminated subject to a thirty (30) day written notice and appeal rights as outlined in Section B.3, below, for:

   a. failure or refusal to cooperate in Coordination of Benefits or Subrogation activities; or

   b. failure to pay applicable Co-Insurance.

3. **Appeal Procedure**

   a. **Concealment, Misrepresentation or Fraud**

      A Covered Person may appeal a termination due to concealment, misrepresentation or fraud. Any such appeal must be submitted in writing, addressed to " Employee Benefits Division for the State of Arkansas, Department of Finance and Administration." In order for the appeal to be considered, EBD must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U. S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to his or her Employer; or (ii) the termination effective date stated in the termination notice letter to the Covered Person.

   b. **Other Causes**

      A Covered Person may appeal a termination due to any of the other causes

outlined in ARTICLE V.B.2. Any such appeal must be submitted in writing, addressed to " Employee Benefits Division for the State of Arkansas, Department of Finance and Administration." In order for the appeal to be considered EBD must receive the appeal prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U. S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to his or her Employer; or (ii) the termination effective date stated in the termination notice letter to the Covered Person.

4. **Effective Dates of Terminations for Cause**

a. **Concealment, Misrepresentation or Fraud**

Termination due to concealment, misrepresentation or fraud shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U. S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to his or her Employer; or (ii) the date stated in the termination notice letter to the Covered Person.

b. **Other Causes**

Termination due to any other cause shall be effective upon the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U. S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to his or her Employer; or (ii) the date stated in the termination notice letter to Covered Person.

C. **Termination of the Plan, Impact on Covered Persons**. The coverage of all Covered Persons shall terminate if the Plan is terminated.

ARTICLE VI. CONTINUATION PRIVILEGES

A. Because COBRA Continuation: Section 42 U.S.C §300bb-1 (COBRA) applies to the Plan, the coverage of an Employee or Dependent whose coverage ends due to a Qualifying Event may be continued while the Group Policy remains in force subject to the terms of this section and all terms and provisions of the Plan not inconsistent with this section.

This provision shall not be interpreted to grant to any Covered Person any continuation rights under the Plan in excess of those required by COBRA.

1. Qualifying Events. The following is a list of events, which could result in termination of a Covered Person's coverage under the Plan. If such should occur, for purposes of this section, the event shall be called a Qualifying Event.

a. An Employee's death.

b. Termination of an Employee's employment (other than by reason of the Employee's gross misconduct), or of an Employee's eligibility due to reduction in the Employee's hours of employment.

c. An Employee's and Spouse's divorce or legal separation.

d. An Employee becoming entitled to Medicare.

e. A Dependent child ceasing to be a Dependent Child as defined by the Plan.

2. Requirements for COBRA Continuation: Continuation under this section is subject to a Covered Person requesting it and paying any required contributions to the Plan within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:

   a. the Covered Person must notify EBD within 60 days of the happening of qualifying event (c) or (e) above; and

   b. the Covered Person must elect to continue coverage under the Plan within sixty (60) days of the later of:

      (1) the date the notification of election rights is sent, or

      (2) the date coverage under the Plan terminates.

   If an election is not made by the Covered Person within this sixty (60) day period, the option to elect COBRA shall end.

3. If an Employee with Dependent coverage requests continuation of coverage under this section, such request shall include the Dependent coverage, unless the Employee asks that it be dropped. In like manner, such a request on the part of the covered Spouse of an Employee shall include coverage for all Dependents of the Employee who were covered.

   Coverage Continued. The coverage continued for a Covered Person in accordance with this section shall be the same as otherwise provided under the Plan for other Covered Persons in the same benefit class in which such Covered Person would have been covered had his coverage not terminated.

4. Termination. Once in effect, COBRA continuation coverage for a Covered Person under this section shall terminate on the earliest of the following applicable dates:

   a. the date the Group Policy terminates;

   b. at the end of the last period for which premium contributions for such coverage have been made, if the Covered Person or other responsible person does not make, when due, the required premium contribution to the Group;

   c. the date ending the maximum period. In the case of Qualifying Event B.1.b above (relating to termination of employment or reduction in hours), this date shall be the date eighteen (18) months after the date of that Qualifying Event; unless the Employee is disabled at the time of, or within sixty (60) days after, his termination or reduction in hours, in which case this date shall be twenty-nine (29) months after the Qualifying Event. In all other cases, such date shall be the date thirty-six (36) months after the date of that Qualifying Event which applies;

   d. the date the Covered Person becomes eligible under any other group health plan;

   e. the date the Covered Person becomes entitled to Medicare; or

   f. the date the Covered Person is terminated for cause (See Section B of ARTICLE V. above).

Any PSE member who retires and elects COBRA, he/she must keep COBRA the entire election period to qualify for the Retirement Benefit

B. **Retirement Continuation**

1. Qualifications. An Employee who terminates active employment may continue coverage under the Plan as a retiree:

   a. If the Employee is a member of:

      The Arkansas Public Employees' Retirement System, or the Arkansas Teacher Retirement System, Judicial Retirement System, or Arkansas State Highway System;

   b. If the Employee's coverage under the Plan is in effect on the last day of the Employee's employment or if the Employee retired after April 18, 2001 and was eligible for coverage upon his retirement date;

   c. If the Employee makes a timely election of continuation of coverage in accordance with Arkansas Code Annotated Section 21-5-411 as amended and the rules promulgated under this law by the EBD;

   d. If the Employee pays the appropriate contribution required to continue the coverage from the date his employment ends.

2. Election to Decline Retirement Continuation. Any election to decline continuation of coverage is final, except that a qualified retiree may later elect coverage under a Special Enrollment Period. (See Section I. of ARTICLE IV.)

3. Term of Retirement Continuation and Addition of Dependents:

   a. The term of continuation coverage for a retired Employee and his Dependents is governed by ARTICLE V. above.

   b. Dependents may be added to a retired Employee's coverage only as a result of a Special Enrollment Period. (See Section I. of ARTICLE IV.)

ARTICLE VII. HOSPITAL BENEFITS

IMPORTANT NOTICE:

IF YOU USE A HOSPITAL, WHICH HAS A CONTRACT WITH THE CLAIMS ADMINISTRATOR, SUCH HOSPITAL HAS AGREED TO ACCEPT THE PLAN'S PAYMENT FOR COVERED SERVICES AS PAYMENT IN FULL EXCEPT FOR YOUR DEDUCTIBLE AND CO-INSURANCE, IF APPLICABLE. IF YOU USE A NON-PREFERRED HOSPITAL, IT IS FREE TO BILL YOU CHARGES FOR COVERED SERVICES WHICH ARE IN EXCESS OF THE PLAN'S PAYMENT. CHECK WITH YOUR EMPLOYER OR CALL THE CLAIMS ADMINISTRATOR FOR A LIST OF PREFERRED HOSPITALS OR VISIT THE CLAIMS ADMINISTRATOR'S WEBSITE AT www.arkansasbluecross.com

Subject to all terms, conditions, exclusions and limitations of the Plan, after a Covered Person meets the Deductible (if applicable) the Plan will pay the Appropriate Co-Insurance percentage (the reciprocal of the percentage shown in the Schedule of Benefits) for the following benefits:

A. Eligibility for Hospital Service Benefits:

Hospital service benefits shall be available to you when:

1. Hospital service is necessitated by your illness or Accidental Injury;
2. it is recommended by a duly licensed Physician who is privileged to practice in the Hospital to which such recommendation is directed; and,
3. You are admitted to the Hospital as an inpatient.

B. **Extent and Duration of Hospital Service Benefits**

Subject to limitations contained herein, you shall be entitled to Hospital service benefits under the Plan for each admission when treatment for the condition requires inpatient care and when services and supplies are:

1. provided by a Hospital;
2. prescribed by a Physician;
3. used by you during the admission;
4. billed for by the Hospital;
5. administered by an employee of the Hospital who is not compensated by a percentage of fees or other commission arrangement; and
6. necessary for the care and treatment of your illness or injury.

C. **Limitations of Hospital Service Benefits**

1. For Hospital admissions out of the state of Arkansas, the Covered Person is requested to notify the Claims Administrator. Call 1-800-451-7302 to notify the Plan.
2. Room Allowance. The daily room and board allowance shall not exceed the Appropriate Co-Insurance percentage of the Charge of the admitting Hospital for a semi-private room. If you use a private room in a Hospital offering both private and semi-private rooms, the Plan will pay an amount equal to the Appropriate Co-Insurance of the average semi-private room Charge for the admitting Hospital. If you are admitted to a Hospital offering only single occupancy rooms, the Plan will apply ninety percent (90%) of the Appropriate Co-Insurance amount to the private room Charge to calculate the room and board allowance.
3. The Plan will pay for Maternity Care, Obstetrical Care and Complications of Pregnancy. The Plan will pay routine nursery Charges for well baby care, provided such payment will be limited to a period of five (5) days or until the mother is discharged, whichever is the lesser period. The Employee must give notice of the birth of the Child by either (i) submitting an application or change form within 30 days of the Child's date of birth if the Employee has an individual or employee and spouse coverage or (ii) submitting a change form within 90 days if the Employee has other than an individual or employee and spouse coverage.
4. Hospital services in connection with Mental Health Services and substance abuse treatment rendered by a Behavioral Health Care Provider are not described in this SPD. See ARTICLE XII., Section MM and the Behavioral Health portion of this SPD. A Covered Person requiring coverage for Mental Health Services and substance abuse treatment from a Behavioral Health Care Provider should contact

the CorpHealth at 1-866-378-1645. CorpHealth is the behavioral health company under contract with EBD to provide coverage for such services or treatment.

5 Payment for Hospital Charges for inpatient admissions shall be limited to the lesser of the billed charge or the maximum allowable payment established by the Plan.

6. Payment for Hospital Charges for outpatient services shall be limited to the lesser of the billed charge or the maximum allowable payment established by the Plan.

7. In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, the Plan will pay that portion of the Hospital Charge which is attributable to services rendered for the covered benefit.

8. Services rendered to you for organ transplants. All organ transplants including autologous bone marrow transplantation, allogeneic bone marrow transplantation, nonmyeloablative allogeneic stem cell transplantation, stem cell rescue and similar treatments or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells are subject to the provisions of ARTICLE IX., T. and ARTICLE XII., X. of this SPD.

9. Services rendered in a Hospital outside of the United States of America will be paid at the sole discretion of the Plan and further subject to the Plan's definition of Charge. See ARTICLE II. G.

10. If you have contracted a contagious disease and it is Medically Necessary that you be isolated from other patients, the Plan will pay for an isolation unit equipped and staffed as such. The Plan will not pay for such services when rendered in a private room setting.

11. Rehabilitation services rendered to you in a Skilled Nursing Facility or rehabilitation center are covered, subject to the Deductible and Co-Insurance, and are further limited to not more than 60 days per Benefit Year. Services for Custodial Care are not covered. See ARTICLE XII., Section T.

ARTICLE VIII. OUTPATIENT CARE

A. Hospital, Surgery Centers, and Radiation Therapy Centers. Subject to all terms, conditions, exclusions and limitations of this SPD, after a Covered Person meets the Deductible (if applicable) the Plan will pay the Appropriate Co-Insurance percentage (the reciprocal of the percentage shown in the Schedule of Benefits for outpatient services in a Hospital, Outpatient Surgery Center, or Radiation Therapy Center.

B. Outpatient Charges. Subject to all terms, conditions, exclusions and limitations of the Plan, Charges for the use of operating or treatment rooms in a Hospital outpatient department and Outpatient Surgery Centers are covered. Payment for Hospital Charges for outpatient services shall be limited to the lesser of the billed Charge or the maximum allowable payment established by the Plan.

ARTICLE IX. OTHER COVERED MEDICAL EXPENSES

IMPORTANT NOTICE:

IF YOU USE A PHYSICIAN WHO IS A PREFERRED PROVIDER, SUCH PHYSICIAN HAS

AGREED TO ACCEPT THE PLAN'S PAYMENT FOR COVERED SERVICES AS PAYMENT IN FULL EXCEPT FOR YOUR DEDUCTIBLE AND APPROPRIATE CO-INSURANCE, IF APPLICABLE.

IF YOU USE A PHYSICIAN WHO IS A NON-PREFERRED PROVIDER, SUCH PHYSICIAN IS FREE TO BILL YOU CHARGES FOR COVERED SERVICES IN EXCESS OF THE PLAN'S PAYMENT. CALL THE CLAIMS ADMINISTRATOR FOR A LIST OF PREFERRED PROVIDERS OR VISIT THE CLAIMS ADMINISTRATOR'S WEBSITE www.arkansasbluecross.com.

Subject to all terms, conditions, exclusions and limitations of the Plan, after a Covered Person meets the Deductible (if applicable) the Plan will pay the Appropriate Co-Insurance percentage (the reciprocal of the percentage shown in the Schedule of Benefits) for the following that are performed or prescribed by a Physician:

A. Physician services. If two or more operations are performed at the same time through the same surgical opening or by the same surgical approach, or for bilateral procedures, payment for the secondary procedure will be made at fifty percent (50%) of UCR if otherwise a covered benefit. Further, the Plan's payment for an assistant surgeon shall be limited to one such assistant.

B. X-ray and diagnostic laboratory procedures.

C. Radiation therapy.

D. Chemotherapy for cancer. (High dose Chemotherapy is subject to the provisions of ARTICLE IX., T. and ARTICLE XII., X.)

E. Renal Dialysis.

F. Oxygen and its administration.

G. Blood transfusions, including cost of blood, blood plasma and blood plasma expanders. (Autologous bone marrow transplantation, allogeneic bone marrow transplantation, nonmyeloablative allogeneic stem cell transplantation, stem cell rescue or similar treatment or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells are subject to the provisions of ARTICLE IX., T. and ARTICLE XII., X.).

H. Services if performed by a therapist licensed by the appropriate State Licensing Board and are furnished in accordance with a written treatment Plan established and certified by the treating Physician for physical, occupational, cardiac rehabilitation, chiropractic services and speech therapy, except Maintenance Therapy (See ARTICLE II., II. for the definition of Maintenance Therapy.) The Plan will not pay for more than 60 aggregate visits, per Benefit Year.

I. Services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), when such services are provided in a home setting through a home health care agency contracted with the Claims Administrator to provide such services, provided the nurse is not related to you by blood or marriage and does not ordinarily reside in your home. Maximum payment for such services shall be limited to 120 visits per Covered Person per Benefit Year.

J. Ambulance Service to the nearest Hospital offering the services required by you in a regularly equipped ambulance is covered in the event of an Emergency. Ambulance Service as an alternate means of transportation is not covered. Ambulance Services are limited to $1,000 per Benefit Year. This limitation applies to air ambulance services. Life saving medications,

oxygen and life support are not subject to this limit.

K. Rental of Durable Medical Equipment (which does not include air-conditioners, dehumidifiers, humidifiers, air purifiers, hot tubs, vacuum cleaners, exercise equipment or comfort items) for use in the home if prescribed by a Physician and required for temporary therapeutic use. If, in the judgment of the Claims Administrator, purchase of an item of Durable Medical Equipment will be less expensive than rental or if such equipment is not available for rental, such purchase may be a covered medical expense if authorized by the Claims Administrator in writing before such purchase is made. Durable Medical Equipment (purchase and lease combined) is limited to $10,000 per Covered Person per Benefit Year.

L. Prosthetic appliances necessary for the alleviation or correction of conditions arising out of Accidental Injury occurring or illness commencing after your effective date of coverage hereunder, or if the necessity for such prosthetic appliances, or their repair, is medically determined subsequent to coverage hereunder, it shall be deemed a covered medical expense, regardless of the date of the accident or illness. Prosthetic Appliances are covered subject to the $15,000 per Benefit Year Prosthetic Appliances limit (see ARTICLE IX., K., above).

M. Anesthetic and administration thereof, if administered by an M.D., CRNA or oral surgeon who is certified to administer anesthesia.

N. Nursing Home Care: Following a Hospital confinement of at least five (5) consecutive days, Charges for Nursing Home confinement will be covered up to the maximum allowable daily rate for Nursing Home confinements for a maximum of sixty (60) days per Benefit Year provided such confinement begins within seven (7) days after Hospital discharge and is for the same or related cause as the Hospital confinement and is recommended by your Physician.

O. Oral Surgery. Oral Surgery is limited to <u>only</u> the following non-dental surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examinations are required.
2. Surgical procedures required to correct accidental injuries or SjÖgren's Syndrome (See ARTICLE II., A for the definition of Accidental Injury.) of jaws, cheeks, lips, tongue, roof and floor of the mouth and only affected teeth.
3. Excision of exostoses of jaws and hard palate.
4. External incision and drainage of cellulitis.
5. Incision of accessory sinuses, salivary glands or ducts.
6. Oral surgery Charges by a Doctor of Dental Surgery (D.D.S.) for the extraction of impacted wisdom teeth and the extraction of teeth effected by SjÖgren's Syndrome.

P. Subject to Deductible and Appropriate Co-Insurance, the Plan will pay for Routine Prenatal Care, Maternity Care, Obstetrical Care, and Complications of Pregnancy for the Employee or the Spouse of the Employee. Routine ultrasounds in normal obstetrical prenatal care are not a covered benefit. The Plan will pay pediatric Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is a lesser period) <u>only</u> if the Covered Person is enrolled under classification II [EMPLOYEE, SPOUSE AND CHILD(REN)] or III [EMPLOYEE AND CHILD(REN)] unless the Employee fails to add the newborn Child to the Plan within ninety (90) days of his birth.

Q. Eye glasses or contact lens after cataract surgery.

1. Coverage limited per lifetime to one pair of glasses or one contact lens per eye per Covered Person.

2. Glasses or contact lens must be delivered within six (6) months of the cataract surgery.

R. Reconstructive surgery is covered:

1. when it is incidental to treatment of disease;

2. for follow-up to trauma which occurred while the Covered Person has been covered by this contract or is in the process of reconstructive treatment resulting from trauma which occurred prior to benefit coverage; or

3. to correct a congenital disease or anomaly that results in a functional defect for a Covered Person born while covered by this contract or for a Covered Person born prior to benefit coverage but who is in the process of reconstructive treatment at enrollment.

S. Subject to all terms, conditions, exclusions and limitations of the Plan, the Plan will provide the following for Children's preventive health care services for eligible dependents from birth through age eighteen (18), subject to the following limitations:

1. Covered services are limited to medical history; physical examination, including routine tests and procedures to detect abnormalities or malfunctions of bodily systems and parts; developmental assessment; anticipatory guidance, including visual evaluation, hearing evaluation, dental inspection for children under two years of age and nutritional assessment; appropriate immunizations; and laboratory tests.

2. Coverage is limited to not more than twenty (20) visits. A covered visit is one occurring during one of the following intervals. at birth; within two (2) weeks after birth; within two (2) weeks preceding or following the date the eligible dependent reaches the following ages. two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, and eighteen (18) months; or within one (1) month preceding or following the date the eligible dependent reaches the following ages. two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years.

3. Coverage for any visit is limited to services provided by or under the supervision of a single Physician.

4. After the Deductible is paid, the Plan will pay the percentage set forth on the Schedule of Benefits of Charges for Children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for recommended immunization services shall be exempt from any copayment, Co-Insurance, Deductible or dollar limit provisions.

T. Organ Transplant Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this SPD, coverage is provided for human to human organ or tissue in accordance with the following specific conditions:

1. Not all transplants are covered. There must be a specific Coverage Policy, which

allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this SPD.

2. Coverage for transplant services requires prior approval by the Plan. A request for approval must be submitted to the Plan prior to receiving any transplant services, including transplant evaluation. Please note that prior approval does not guarantee payment or assure coverage; it means only that the information furnished to the Plan at the time indicates that the transplant is medically necessary. All services, including any transplant receiving prior approval, must still meet all other coverage terms, conditions and limitations, and coverage for any transplant receiving prior approval may still be limited or denied if, when the claims for the transplant are received by the Plan, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this SPD or of the applicable Coverage Policy.

3. The transplant benefit is subject to the Deductible and Co-Insurance specified in the Schedule of Benefits.

4. All organ transplants and related services are subject to this SPD's Lifetime Maximum as stated in the Schedule of Benefits.

5. Notwithstanding any other provisions of this SPD, at the option of Plan, the Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety (90%) of the billed charges or (b) the global payment accepted as payment in full by a Blue Cross and Blue Shield Association Blue Quality Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Quality Centers for Transplant network, the Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of an amount equaling the lesser of (a) ninety (90%) percent of billed charges or (b) the average allowable charge authorized by participating facilities in the Blue Quality Centers for Transplant network located in the geographic region where the transplant is performed. Please note that the Claims Administrator's payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; the Plan will not pay any amounts in excess of the global payment for services the facility or any physician or other health care provider or supplier may bill or attempt to bill separately because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If the Covered Person uses a facility participating in the Blue Quality Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill the Covered Person for any excess amount above the global payment, except for applicable Deductible, Co-insurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

6. Donor testing is covered only if the tested donor is found to be compatible.

7. Coverage is limited to no more than 2 transplants per Covered Person per lifetime. Multi-visceral transplants done simultaneously where this is the standard of care as expressed in Coverage Policy are to be considered one transplant for purposes of this limitation. Retransplantation is covered but is not counted as a second transplant for purposes of this two-transplant limitation.

8. Coverage is limited to the transplantation of human organs or tissue. The insertion of animal, artificial or mechanical devices designed to replace human organ(s) permanently is not covered.

9. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission. A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.

10. Autologous Transplants. The Plan does not generally cover autologous bone marrow transplantation and all related procedures (including high dose Chemotherapy, with or without radiotherapy) designed to replace bone marrow or peripheral cells. There is no coverage for high dose Chemotherapy with stem cell support for diseases that are not either specifically listed as exceptions and therefore covered in subsections T. (10.) or (11.) of this SPD, or specifically listed as exceptions and therefore covered in specific Coverage Policies. Tandem transplants (transplants done within approximately 3 to 6 months of the initial transplant, and done to increase the chance of inducing a remission) are covered only for a diagnosis of multiple myeloma.

    The only instances in which drugs, services or supplies associated with high dose Chemotherapy and related procedures for autologous stem cell support will be eligible for benefits are in the case of autologous bone marrow, stem cell or progenitor cell transplant with or without high dose Chemotherapy for the following diseases under the following circumstances:

    a. Non-Hodgkin's lymphoma: for failure to achieve complete remission after initial therapy for newly diagnosed lymphoma; for relapsed disease after a complete remission of intermediate or high grade lymphoma that has not undergone transformation; therapy of relapsed low grade follicular lymphoma that has not undergone transformation;

    b. Hodgkin's Disease: primary refractory Hodgkin's disease or disease relapsing less than one year after completion of an initial course of chemotherapy;

    c. Neuroblastoma: for initial treatment of high risk neuroblastoma (high risk includes: stage II and > 10 N-myc oncogene; stage III - > 10 N-myc oncogene or ferritin > 143 or unfavorable histology; stage IV and older than 1 year at

time of diagnosis; stage IV at less than 1 year of age at time of diagnosis and > 10 N-myc oncogene); as treatment of primary refractory or recurrent neuroblastoma;

d. Acute lymphocytic leukemia (ALL) in adults: in first complete remission but at high risk of relapse (Risk factors for high risk of relapse include a) age greater than 15 years; b) leukocyte count > 10 x 10^9/L; c) extramedullary disease, particularly CNS; d) chromosomal abnormalities, including Philadelphia chromosome; e) failure to achieve a complete remission within 6 weeks of the start of induction therapy)

e. Acute lymphocytic leukemia (ALL) in children: in second or greater remission or refractory ALL.

f. Acute Myelogenous Leukemia (AML): in first complete remission at high risk for relapse (usually reserved for patients with high risk features that include AML secondary to prior chemotherapy and/or radiotherapy for another malignancy; presence of circulating blasts at the time of diagnosis; difficulty in obtaining first complete remission; leukemia with monocytoid differentiation; certain cytogenic abnormalities, such as abnormalities of chromosome 12, deletions of chromosomes 5 and 7, or trisomy of chromosome 8); treatment of primary refractory or relapsed AML;

g. Germ cell tumors (testicular, mediastinal, retroperitoneal or ovarian germ cell tumors): as treatment of germ cell tumors that do not achieve a complete remission, i.e., refractory tumors (less than 50% reduction in tumor burden) or those exhibiting a partial response; treatment of patients in second complete remission or in second relapse;

h. Multiple Myeloma: newly diagnosed or responsive, either complete or partial remission (at least a 50% reduction in tumor burden). Multiple myeloma includes Waldenstrom's macroglobulinemia, but does not include amyloidosis. Coverage includes tandem transplants. Multiple myeloma is the only indication for which a tandem transplant is covered.

i. Primitive Neuroectodermal Tumors (PNET) (medulloblastoma, neuroblastoma arising in the central nervous system, ependymoblastoma, pineoblastoma): for the treatment of recurrent or refractory medulloblastoma and other primitive neuroectodermal tumors

j. Ewing's Sarcoma: treatment of metastatic or refractory disease

11. Allogeneic Transplants. The Plan does not generally cover allogeneic bone marrow transplantation and all related procedures (including high dose Chemotherapy, with or without radiotherapy) designed to replace bone marrow or peripheral cells. There is no coverage for high dose Chemotherapy with stem cell support for diseases that are not either specifically listed as exceptions and therefore covered in subsections T. (10.) or (11.) of this SPD, or specifically listed as exceptions and therefore covered in specific Coverage Policies.

    High dose Chemotherapy with allogeneic stem cell support is not covered when used for any relapsing disease previously treated with high dose Chemotherapy and autologous stem cell support.

The only instances in which services, supplies or drugs associated with allogeneic transplantation and related procedures will be eligible for benefits are as follows:

a. Allogeneic bone marrow, stem cell or progenitor cell transplants for development diseases of the bone marrow or nonmalignant diseases of the bone marrow:

   (1) Aplastic anemia;

   (2) Wiskott-Aldrich syndrome;

   (3) Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease);

   (4) Homozygous beta-thalassemia (thalassemia major);

   (5) Myelodysplastic syndrome (refractory anemia with excess blasts, refractory anemia with excess blasts with transformation, or chronic myelomonocytic leukemia); myeloproliferative disorders (progression to myelofibrosis, evolution toward acute leukemia, or essential thrombocythemia with thrombotic or hemorrhagic disorder

   (6) Children and young adults with homozygous sickle cell anemia and a history of prior stroke;

   (7) Mucopolysaccharidoses in patients who are neurologically intact;

   (8) Mucolipidoses for patients who have failed conventional therapy and who are neurologically intact;

   (9) Kostmann's syndrome

   (10) Leukocyte adhesion deficiencies

   (11) X-linked lymphoproliferative syndrome

   (12) Severe combined immunodeficiency syndrome (e.g. adenosine deaminase deficiency and idiopathic deficiencies).

b. Allogeneic bone marrow, stem cell, or progenitor cell transplant with or without high dose chemotherapy for the following diseases:

   (1) Non-Hodgkin's lymphoma: for failure to achieve complete remission after initial therapy for newly diagnosed lymphoma; for relapsed disease after a complete remission of intermediate or high grade lymphoma that has not undergone transformation; therapy of relapsed low grade follicular lymphoma that has not undergone transformation;

   (2) Hodgkin's Disease: primary refractory Hodgkin's disease or disease relapsing less than one year after completion of an initial course of chemotherapy;

   (3) Neuroblastoma: for initial treatment of high risk neuroblastoma (high risk includes: stage II and > 10 N-myc oncogene; stage III - > 10 N-myc oncogene or ferritin > 143 or unfavorable histology; stage IV and older than 1 year at time of diagnosis; stage IV at less than 1 year of age at time of diagnosis and > 10 N-myc oncogene); as treatment of primary

refractory or recurrent neuroblastoma;

(4) Chronic myelogenous leukemia

(Donor leukocyte infusion is covered for patients with chronic myeloid leukemia that has relapsed into the chronic phase after a prior allogeneic transplant);

(5) Acute lymphocytic leukemia in first or subsequent remission, but at high risk for relapse. Factors associated with high risk for relapse include: age greater than 15 years; leukocyte count greater than 10 x 10^9 /L; extramedullary disease (especially central nervous system disease; chromosomal abnormalities, including Philadelphia chromosome; and failure to achieve a complete remission within six weeks of the start of induction therapy); for patients in second or greater remission; for patients with relapsed or refractory disease;

(6) Acute myelogenous leukemia (AML) in first complete remission at high risk for relapse (usually reserved for patients with high risk features that include AML secondary to prior chemotherapy and/or radiotherapy for another malignancy; presence of circulating blasts at the time of diagnosis; difficulty in obtaining first complete remission; leukemia with monocytoid differentiation; certain cytogenic abnormalities, such as abnormalities of chromosome 12, deletions of chromosomes 5 and 7, or trisomy of chromosome 8); treatment of primary refractory or relapsed AML.

12. Nonmyeloablative Allogeneic Stem Cell Transplantation. Nonmyeloablative allogeneic stem cell transplants consist of infusions of allogeneic stem cells that can engraft in recipients using less intensive conditioning regimens that are sufficiently immunosuppressive to permit graft-host tolerance. Donor leukocyte infusions may be administered as part of this therapy.

The only instances in which these services, supplies or drugs associated with nonmyeloablative allogeneic stem cell transplantation and related procedures will be eligible for benefits are:

a. For patients who would also meet patient selection criteria for high dose chemotherapy and allogeneic stem cell transplantation (see selection criteria in coverage for Non-Hodgkin lymphoma, myelodysplastic disease, acute myelogenous leukemia, Hodgkin's Disease, chronic myelogenous leukemia, and acute lymphocytic leukemia);

b. For patients with aplastic anemia who fail treatment with immunosuppressive regimens and do not have a sustained response to growth factor therapy.

There is no coverage for nonmyeloablative allogeneic stem cell transplantation for diseases not covered in this subsection T. (12.), or in a Coverage Policy.

U. The Plan will pay for one Diabetes Self-Management Training Program per lifetime per Covered Person. If there is significant change in the Covered Person's symptoms or conditions which would make it Medically Necessary to change the Covered Person's diabetic management process, the Plan will pay for an additional Diabetes Self-Management

Training Program. This benefit is payable in or out of the Hospital and must be prescribed by a Physician.

The Plan will pay for Medically Necessary equipment, supplies and services for the treatment of diabetes. Reimbursement for supplies is limited to supplies not covered by the Prescription Medication Program.

NOTE: Insulin Pump supplies, bent needles, reservoirs, and tubing are covered by the Plan, as are glucometers. Insulin, test tapes, syringes and lancets are covered under a separate prescription drug plan authorized by the EBD.

V. Surgery and Services After Mastectomy. In connection with a covered mastectomy due to cancer, surgery and services for (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Covered Person.

W. After the Deductible, the Plan will pay the Appropriate Co-Insurance amount set forth in the Schedule of Benefits for Medical Foods and Low Protein Modified Food Products for the treatment of a Covered person diagnosed with phenylketonuria if:

1. The Medical Foods and Low Protein Modified Food Products are administered under the order of a licensed Physician: and
2. The Medical Foods and Low Protein Modified Food Products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria.

X. Mammoplasty (breast reduction) is covered if it: (a) meets Medical Necessity and (b) is pre-authorized.

Y. Elective sterilization (a) vasectomy and (b) tubal ligation.

Z. Routine mammography and routine pap smears, annually.

AA. Mental Health Services and substance abuse treatment rendered by a family practitioner, general practitioner, internal medicine practitioner or pediatrician who does not specialize or concentrate their practice in mental health or substance abuse treatment. A Covered Person requiring coverage for Mental Health Services and substance abuse treatment from a Behavioral Health Care Provider should contact CorpHealth. CorpHealth is the behavioral health company under contract with EBD to provide coverage for such services or treatment.

BB. Temporomandibular Joint (TMJ) Dysfunction. Subject to all terms, conditions, exclusions and limitations of the Plan, after a Covered Person meets the Deductible (if applicable) the Plan will pay the Appropriate Co-Insurance percentage (the reciprocal of the percentage shown in the Schedule of Benefits) for Medically Necessary diagnostic procedures, evaluations, surgical treatment, intra-oral reversible prosthetic devices and pharmacological treatment of the temporomandibular joint. This TMJ benefit is subject to a $500 maximum per Covered Person per lifetime.

CC. Home Infusion IV Drugs, Solutions and Supplies.

DD. Subject to the limitations herein, In-vitro fertilization is covered benefit provided:

1. The patient is an Employee or is a covered dependent as the spouse of such an

Employee, and

2. The patient's oocytes are fertilized with the sperm of the patient's spouse, and

3. The following facts are medically documented:

   a. The patient and the patient's spouse have a history of unexplained infertility of at least two (2) years duration: or

   b. The infertility is associated with one or more of the following medical c onditions:

      i. Endometriosis;

      ii. Exposure in utero to Diethylstilbestrol (DES);

      iii. Blockage of or removal of one or both fallopian tubes not a result of volutary sterilization.

      iv. Abnormal male factors contributing to such infertility, and,

4. The In-vitro fertilization procedures are perfomed at a facility licensed by the Arkansas Department of Health as an In-vitro fertilization clinic, or if such is unavailable, in a clinic elsewhere which is approved by the Company, and

5. The lifetime maximum benefits available under your policy or Certificate for all fertilizations procedures, including In-vitro fertilization, shall not exceed the sum of Fifteen Thousand Dollars ($15,000.00).

NOTE: Prescription drugs for In-vitro fertilization are not covered under this Benefit Certificate.

ARTICLE X. DEDUCTIBLES AND ANNUAL CO-INSURANCE LIMIT

A. **Deductibles**

1. Whenever any two (2) Covered Persons with family coverage have each incurred covered medical expenses exceeding the Deductible amount for the Benefit Year, other Covered Persons under such coverage who incur covered medical expenses subsequent to the date upon which the second Deductible was met will be considered to have satisfied the Deductible amount requirements hereunder for that Benefit Year.

2. If a Covered Person is confined in a Hospital and such confinement extends into a new Benefit Year, benefits will be paid as one benefit period until the Covered Person is discharged from the Hospital.

B. **Annual Co-Insurance Limit**

In Network the Plan will pay eighty percent (80%) of allowed Charges, after the Deductible, for each Covered Person until the person has accumulated $3,000 Co-insurance expenses or the family has accumulated Co-insurance expenses of $6,000 in a Benefit Year. For Out-of-Network services the Plan will pay sixty percent (60%) of allowed Charges, after the Deductible, for each Covered Person until the person has accumulated $8,000 Co-insurance expenses or the family has accumulated $16,000 Co-insurance expenses in a Benefit Year. The Plan will pay one hundred percent (100%) of remaining allowable Charges

for that Benefit Year. Out-of-Network benefits are payable up to the lifetime maximum of $1,000,000 per Covered Person. If Hospital confinement extends into a new Benefit Year, benefits will be paid as one benefit period until the Covered Person is discharged from the Hospital.

Co-Insurance payments for Ambulance Services, Durable Medical Equipment, physical therapy, occupational therapy, cardiac rehabilitation, chiropractic services, speech therapy, home health nursing services and TMJ treatments are credited towards the Annual Co-Insurance Limit, but payment therefore shall be limited to both the maximum amounts payable and the visit limits set forth in ARTICLE IX., Sections J, K, H, I and BB, respectively of this SPD.

ARTICLE XI. CO-INSURANCE and PPO EXCEPTIONS

A. The reciprocal of the PPO Network or In-Network Co-Insurance percentage set forth in the Schedule of Benefits is applied to Charges for services and supplies a Covered Person receives from a Preferred Provider, unless the Schedule of Benefits or this SPD states a different Co-Insurance percentage for the particular service.

B. The reciprocal of the Non-PPO or Out-of-Network Co-Insurance percentage set forth in the Schedule of Benefits is applied to Charges for services and supplies a Covered Person receives from a Non-Preferred Provider, unless:

1. the Schedule of Benefits or this SPD provides a different Co-Insurance for the particular service; or

2. the Covered Person is a dependent with a permanent residence outside of Arkansas, in which case the Co-Insurance percentage shall be eighty percent (20%) unless subparagraph B.1. above applies; or

3. the services are the result of an Emergency (see ARTICLE II., Y.); initial services must be provided within forty-eight (48) hours of the Emergency; or

4. prior to the effective date of the Covered Person's coverage, the Covered Person was engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under the terms of this policy, such condition requiring immediate care, and the Covered Person notifies the Claims Administrator of a request to continue such scheduled procedure or ongoing treatment. If the Claims Administrator approves the scheduled procedure or ongoing treatment, In-Network Co-Insurance will apply to services and supplies rendered by the Out-of-Network Provider for such condition after the Claims Administrator's approval for the period specified by the Claims Administrator; or

5. prior to the effective date of coverage, the Covered Person was receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of the Plan, and the Covered Person notifies the Claims Administrator of a request to continue receiving obstetrical care from this Provider. If the Claims Administrator approves the requested obstetrical care, In-Network Co-Insurance will apply to services and supplies received from this Provider after the Claims Administrator's approval and will continue to apply to services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or

6. the Covered Person has notified the Claims Administrator at least forty-eight (48) hours prior to receiving such services or supplies and the Claims Administrator affirms that such services or supplies are not available from a Preferred Provider.

ARTICLE XII. BENEFITS AND SERVICES NOT INCLUDED

In addition to all other terms, conditions, exclusions and limitations in the Plan, the following exclusions and limitations apply:

A. Disease contracted or injuries sustained while serving in the military forces of any nation.

B. Dental Care or orthodontic services are not covered. However, if a Covered Person has an Accidental Injury or SjÖgren's Syndrome, benefits will be provided for Dental Care and x-rays necessary to correct damage to Non-diseased Teeth, affected teeth and surrounding tissue caused by the Accidental Injury or SjÖgren's Syndrome with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury or teeth affected by SjÖgren's Syndrome and the Non-diseased/ affected Tooth or Teeth immediately adjacent will be considered for replacement.

2. Orthodontic services are limited to the stabilization and re-alignment of the accident involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury or diagnosis of SjÖgren's Syndrome. If the Covered Person is under age fifteen (15), reimbursement for Dental Care services provided after such twelve (12) month period will be provided if. (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Claims Administrator, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.

4. Injury to teeth while eating is not considered an Accidental Injury.

5. Double abutments are not covered.

6. Dental implants are not covered, unless such dental implants are necessary due to an Accidental Injury or SjÖgren's Syndrome, as defined herein, occurring on or after the later of the first day of the Benefit Year or the Covered Person's Effective Date.

C. Eye refractions, eyeglasses (except after cataract surgery as limited by the Plan), and hearing aids or the fitting thereof are not covered.

D. Cosmetic Services are not covered.

E. Services or supplies not medically necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered. Services for "Screening Test" are not covered, unless specifically listed as a benefit in this SPD. For purposes of this exclusion, prostate specific antigen (PSA) tests are not covered.

F. Treatment of any compensable injury, as defined by the Arkansas Workers' Compensation Law is not covered, regardless of whether or not the Covered Person timely filed a claim for workers' compensation benefits.

For purposes of this exclusion of coverage, it will be presumed that if the Covered Person makes a claim for workers' compensation benefits, the injury for which the Covered Person makes any such claim is a compensable injury under the Arkansas Workers' Compensation Law, and therefore, the Plan will not be liable for payment of any insurance benefits as to such a claim, unless there is a specific finding by the full Workers' Compensation Commission, not overturned on appeal, that the Covered Person's injury was not a compensable injury. The foregoing presumption of non-coverage under the Plan also applies to any case in which a Covered Person's workers' compensation benefits claim is settled by joint petition or otherwise, in which case no benefits will be paid under the Plan with respect to such a claim, regardless of the settlement amount.

Nor will the Plan pay benefits for injury or illness for which a Covered Person receives any benefits under the Arkansas Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to such benefits claim under such laws.

In the event that the Plan pays any claim for benefits, and subsequently learns that the Covered Person has filed a claim for workers' compensation benefits as to such claim, or that the Covered Person has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Arkansas Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Covered Person agrees to reimburse the Plan to the full extent of the Plan's payments on such claim.

G. Services for which a Covered Person would not be obligated to pay, but for the existence of insurance, rendered in any Hospital operated by the United States or any agency thereof or in any Hospital operated by a state, political subdivision or agency thereof, are not covered unless otherwise required by applicable law.

H. Hospital services when a Covered Person is admitted to a Hospital primarily for diagnostic studies or primarily for X-ray examinations, laboratory examinations, electrocardiograms, or cardiac rehabilitation are not covered.

I. Services or supplies received outside of the United States of America will be covered at the sole discretion of the Claims Administrator.

J. Any experimental or investigational services or supplies or for any condition or complication arising from or related to the use of such experimental or investigational services or supplies are not covered. The Claims Administrator shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational in the Claims Administrator's discretion, if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or

2. the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar

function, or if federal law requires such review and approval; or

3. reliable evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

5. reliable evidence (as defined below) shows that, at the time a claim is presented for coverage of any drug, device, or medical treatment or procedure, the evidence is inconclusive regarding its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment. Evidence will be deemed inconclusive if reliable evidence (as defined below) shows no firm medical consensus or majority opinion either supports or denies use of the drug, device or medical treatment or procedure for a particular condition or disease; or

6. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease; or

7. reliable evidence (as defined below) is that the drug, device or medical treatment or procedure is experimental or investigational or is not safe or effective.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

(b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;

(d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

K. the surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily repositioning of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose are subject to the temporomandibular joint $500 maximum set forth in ARTICLE IX., Section BB.

This means, for example, that if you need a reduction of a dislocation of the temporomandibular joint, we will pay for that reduction up to the $500 maximum, but we will not pay any Charges associated with repositioning of the jaw or repositioning of the segments of the mandible or maxilla, even if such repositioning is performed as part of treatment designed to reduce a dislocation of the temporomandibular joint;

L. The services of social workers are not covered, unless included as a part of the daily room and board allowance.

M. Refractive keratoplasty or epikeratophakia procedures, or any related services performed to correct near sightedness are not covered.

N. Dietary supplements, when used in connection with weight reduction programs, whether dispensed by prescription or otherwise, are not a covered benefit.

O. Services rendered to a Covered Person by an immediate relative are not covered. “Immediate relative” means a Spouse, parents, children, brother, sister, by blood or marriage, or legal guardian of the person who received the services.

P. Orthoptic or pleoptic therapy is not covered.

Q. Wigs or hairpieces are not covered.

R. Services or supplies rendered for treatment of exogenous obesity are not covered.

S. The Plan does not cover foot orthoses for palliative or cosmetic foot care including flat foot conditions, supporting devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet chronic foot strain and symptomatic complaints of the feet.

T. The Plan does not cover Hospital and Physician services for rest cures; Charges for Physician services performed by a Hospital resident, intern or student of any medical discipline, adult immunizations; Charges for Custodial Care; and services or supplies not specifically listed as benefits herein.

U. Services paid or for which a Covered Person is entitled to have paid or to obtain without cost under the laws or regulations of any federal, state or local government or any political subdivision thereof are not covered.

V. Periodontic services which include gum surgery and mucogingivoplastic surgery are not considered oral surgery and are not covered by the Plan.

W. Treatment of gender dysphoria syndrome or transsexualism is not covered.

X. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation except in the limited circumstances set forth in ARTICLE IX., (C)(8.), and ARTICLE XII., (T).

Y. Low Vision Enhancement System (LVES) is not covered.

Z. Genetic testing is limited to those tests approved by the Claims Administrator. Examples of genetic testing that are covered include, but are not limited to, testing for Down’s syndrome, phenylketonuria/galactosemia (PKU), medullary thyroid carcinoma, hypothyroidism and sickle-cell anemia.

AA. The Plan does not cover treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform

the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of the Claims Administrator's Medical Director, include within its scope the treatment, procedure or service provided.

BB. The testing of a transplant donor who is found incompatible is not covered.

CC. The Plan does not cover services or supplies provided by an entity or individual who is not a Provider as defined by the Plan. (See ARTICLE II., Section AAA.)

DD. Prescription Drugs are not covered under this section of this SPD.

EE. Services or supplies provided by a recreational therapist are not covered.

FF. Maintenance Therapy is not covered.

GG. The Plan does not cover biofeedback and other forms of self-care or self-help training and any related diagnostic testing.

HH. Gastric bypass surgery is not covered.

II. Automobile or Van conversion and /or wheel chair lift, overhead lift, automobile hand controls, or ramp for home or automobile are not covered.

JJ. The Plan does not cover any services or supplies provided for Dietary and Nutritional Services, unless such services or supplies are the sole source of nutrition for the Covered adult. Baby formula, whether prescribed by a Physician or acquired over the counter, is not a covered benefit.

KK. High frequency chest wall oscillators are not covered.

LL. Abortion, unless performed in an inpatient or outpatient Hospital setting to save the life of the mother, is not covered. Any abortion performed outside a Hospital setting will be denied.

MM. Mental Health Services and substance abuse treatment rendered by a Behavioral Health Care Provider are not described in this section of this SPD. A Covered Person requiring coverage for Mental Health Services and substance abuse treatment from a Behavioral Health Care Provider should contact CorpHealth, the behavioral health company under contract with EBD to provide coverage for such services or treatment

NN. Hospice care.

OO. Telephone Consultation. Telephone calls by a Provider to the Covered Person for consultation or medical management, or for coordinating care with other health care professionals including reporting or obtaining tests and/or laboratory results except telephone calls made by a Physician responsible for the direct care of a Covered Person in Case Management.

PP. Education Programs. Education programs such as back schools, athletic trainers, educational supplies, work hardening, health club memberships, physician education programs in a group setting, community or work reintegration training are not covered. However, coverage is provided for Diabetes Self-Management Training in accordance with Other Covered Medical Expense.

QQ. Over-the-counter Supplies. Supplies purchased over the counter are not covered. These include disposable liners or shields for incontinence or skin supports for breast prosthesis.

RR. Administrative Fees. Fees incurred for copying medical records, sales tax, preparation of records for other insurance agencies or carriers, medical evaluation for life, disability or any type of insurance coverage are not covered.

SS. Blood Typing. Blood typing for paternity testing is not covered.

TT. Environmental Intervention. Environmental intervention for psychiatric medical management progress purposes on a Covered Person's behalf with agencies, employers or institutions are not covered.

UU. Cochlear Implants. Services related to cochlear implants including diagnostic tests are not covered for Covered Persons over the age of 18 years.

VV. Hypno Therapy. Services for hypno therapy are not covered.

ZZ. Peripheral Nerve Stimulators. Services for peripheral nerve stimulators are not covered.

ARTICLE XIII. OTHER HEALTH PLANS AND BENEFIT PROGRAMS

A. Coordination of Benefits. Coordination of benefits ("COB") applies when a Covered Person has coverage under more than one Health Benefit Plan.

1. Definitions. For purposes of ARTICLE XIII. only, the following words and phrases shall have the following meanings:

a. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan (including this Plan) provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

b. "Health Benefit Plan" means any of the following (including this Plan) which provide coverage for medical care or treatment:

i). Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law. ***If a member is eligible for Medicare the member must take Medicare Part A and B. The premium will not reduce unless the member has both Part A and Part B. Eventually, the plan will pay as if the member had Part B, regardless of whether he/she has Part B.***

ii). Medicare Primary End Stage Renal Disease: If a member is effective with Medicare due to End Stage Renal Disease and has satisfied the required waiting period of 30 months, Medicare will become the primary payer for treatments related to renal disease only. The member must also have Medicare Part B for coverage of services provided on an outpatient basis. Monthly premiums will not decrease until the member reaches 65 years of age and retires.

iii) Group coverage (other than group automobile insurance) or any other

arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage, group practice basis or individual practice coverage or any coverage for students, which is sponsored by, or provided through a school or other educational institution above the high school level.

The term "Health Benefit Plan" shall be construed separately with respect to:

(1) Each policy, contract or other arrangement for benefits or services.

(2) That portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.

2. The Claims Administrator shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering the Covered Person.

The rules establishing the order of benefit determination between the Plan and any other Health Benefit Plan covering the Covered Person on whose behalf a claim is made are as follows:

a. The benefits of a Health Benefit Plan, which does not have a "coordination of benefits with other health plans" provision, shall in all cases be determined and applied to claims before the benefits of the Plan.

b. If according to the rules set forth in Subsection 3.c. of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan.

3. Order of Benefit Determination. Rules establishing the order of benefit determination as to a Covered Person's claim for the purposes of Subsection 2 of this ARTICLE XIII. are as follows:

a. The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent.

b. The benefits of a plan which covers the person on whose expenses a claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other, or each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits; except that

in the case of a person for whom claim is made as a dependent Child:

i). When the parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody of the Child will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody.

ii). When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the step-parent, and the benefits of a plan which covers that Child as a dependent of the step-parent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody.

iii). Notwithstanding subparagraphs i). and ii). of this paragraph, when the parents are divorced or separated and there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the Child, the benefits of a plan which covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the Child as a dependent Child.

c. When paragraphs a. and b. do not establish an order of benefits determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, except that:

i). The benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee or as a dependent of such person shall be determined after the benefits of any other plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person, and

ii). If either plan does not have a provision regarding laid-off or retired employees, and as a result, each plan determines its benefits after the other, then the provisions of subparagraph a. of this paragraph do not apply.

B. Military Benefits. Services and benefits for military service-connected disabilities for which a Covered Person is legally entitled and for which facilities are reasonably available shall in all cases be provided before the benefits of the Plan.

C. The Claims and Plan Administrators' Right to Coverage Information. The Claims and Plan Administrators may, subject to applicable confidentiality requirements set forth in this SPD, release to or obtain from any insurance company or other organization necessary information under this provision. Any Covered Person claiming benefits under the Plan must furnish to the Claims and Plan Administrators all information deemed necessary by it to implement this provision.

The Plan Administrator and the Claims Administrator may, with the consent of the Covered Person, by the existing written release of information contained on the eligibility form, coordinate medical information of the between the pharmacy program and the health program for the purpose of medical management. Such medical information may be shared with the physician, the pharmacist and the case manager for Disease Management and or Case Management purposes. Information shared will be for the sole purpose of assisting the Covered Person and the Plan with utilization management. Failure of the member to provide consent for medical management may result in the loss of benefits for the member.

D. The Plan's Right to Overpayments. Whenever payments have been made by the ‑Plan with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of the Plan, the Plan shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Claims Administrator shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

E. If a Covered Person becomes eligible for Medicare (age 65 or disabled), the Covered Person's coverage will be coordinated with the benefits provided by the Medicare Program.

F. Covered Person's Cooperation. Each Covered Person shall complete and submit to the Claims Administrator such consents, releases, assignments and other documents as may be requested by the Claims Administrator in order to obtain or assure reimbursement under Medicare or workers' compensation. Any Covered Person who fails to so cooperate (including a Covered Person who fails to enroll under Part B and, if eligible, Part A of the Medicare program) will be liable for the amount of funds the Plan would have received had the Covered Person cooperated.

G. Acts of Third Parties (Subrogation). In the event any benefits or services of any kind are furnished to a Covered Person or payment made or credit extended to or on behalf of any Covered Person for a physical condition or injury caused by a third party or for which a third party may be liable, the Plan shall be subrogated and shall succeed to such Covered Person's rights of recovery against any such third party to the full extent of the value of any such benefits or services furnished or payments made or credits extended. The Covered Person shall, at the Plan's request, take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its rights hereunder. In the event of the Covered Person's failure to comply with such request, the Plan shall be entitled to withhold benefits, services, payments, or credits due. The Covered Person shall do nothing after acceptance of benefits hereunder to prejudice the subrogation rights of the Plan.

ARTICLE XIV. OTHER PROVISIONS

A. Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider of medical services or supplies to furnish Claims Administrator, its agents, or any of its subsidiaries, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you

authorize the release of such records to any third party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Claims Administrator about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider so respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Claims Administrator, or failure to cooperate fully to obtain information requested by the Claims Administrator from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.

B. No assignment of benefits under the Plan shall be valid until approved and accepted by Claims Administrator. Claims Administrator has the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to you.

C. Notice and Proof of Claim.

1. You must submit written proof of any services, supplies or treatment and the Charges to the Claims Administrator within one hundred eighty (180) days after such services, supplies or treatment were received.

2. The Claims Administrator, upon receipt of such notice, will furnish to you such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Claims Administrator receives such notice, you shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

3. Subject to all applicable statutory provisions and rules and regulations of the Arkansas Insurance Department, all benefits payable under the Plan will be payable immediately upon receipt of written proof of loss.

D. Upon termination of your employment, (Subject to the conditions of ARTICLE V.) all benefits, except Charges incurred prior to such events, shall cease.

E. Legal Actions. Prior to initiating legal action, you must file an appeal of your claim in accordance with ARTICLE XIV., F. of this SPD. No court suit shall be brought to recover on this SPD before sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this SPD. No legal action shall be brought after the expiration of three (3) years from the time written proof of loss is required to be furnished.

F. How To Appeal A Claim.

1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company, P.O. Box 2181, Little Rock, Arkansas 72203-2181. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your Physician. You or your representative may submit, with your request for review,

any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

3. Subsequent to the determination of the Appeals Coordinator, you can appeal to the Plan Administrator, EBD, Post Office Box 15610, Little Rock, AR 72231.

4 The Plan Administrator acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions shall be conclusive and binding on the Plan and you subject to the grievance and appeals procedures as outlined in this SPD.

G. Out of Arkansas Claims

1. BlueCard Program. In most cases when you receive covered health care outside of Arkansas, the claim from the Provider will be eligible for processing through the Blue Cross and Blue Shield System BlueCard Program. When you obtain health care services through BlueCard outside the geographic area Arkansas Blue Cross and Blue Shield serves, the amount you pay for covered services is calculated on the lower of:

   - The billed charges for your covered services, or
   - The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the Claims Administrator.

2. Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specific group of providers. The negotiated price may also be billed charges reduced to reflect average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

3. Statutes in a small number of states may require a Host Blue to use a basis for calculating Employee or Dependent Co-Insurance liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Employee or Dependent Co-Insurance liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, Arkansas Blue Cross would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received those services.

H. Despite its best efforts, the Claims Administrator may make a claim payment which is not

for a benefit provided under the Plan, or the Claims Administrator may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to the Plan promptly upon a request of the Claims Administrator. If the Claims Administrator does not receive the full amount of the refund due, the Plan will have the right to offset future payments made to you or your Provider under this Plan.

ATTACHMENT A

ARKANSAS PUBLIC SCHOOL EMPLOYEES

PRESCRIPTION DRUG COVERAGE

A Prescription Drug Program is available to employees and dependents enrolled as plan participants in one of the Arkansas State and Public School Employee Benefits Division (EBD) sponsored medical plans. Prescription drug benefits are **not** available **without participation in one of the medical plans.**

Retail Prescription Drug Card Program

Drugs that are prescribed for short-term use (up to a 34-day supply) should be filled using the retail prescription drug card. The Pharmacy Benefit Manager (AdvancePCS) administers the Retail Prescription Drug Card Program**.** This benefit is offered in conjunction with one of the Arkansas State and Public School Employee's Medical Plan options. Participants receive a prescription drug card, which may be used to purchase drugs from one of the AdvancePCS network pharmacies. The AdvancePCS network includes over 700 pharmacies in Arkansas and over 20,000 pharmacies nationwide. Most chain stores such as Wal-Mart, Walgreen's and Kroger participate in this network, as well as many independent pharmacies across the state. Confirmation of participating Pharmacies may be obtained by calling AdvancePCS at 1-877-456-9586 or through its website at http://ar.advancerx.com

The medications eligible for coverage will fall into one of three categories:generic, formulary brand, or non-formulary brand. The co-payment amount is dependent upon whether the prescription is for a generic, a formulary brand name (preferred) drug or a non-formulary brand name (non-preferred) drug.

A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration (FDA) to be therapeutically equivalent, and is as effective as the brand name product. The use of generics and formulary brand name drugs perform a vital role in controlling the cost of prescription drugs for both the participant and the plan. All non-formulary drugs have alternatives available preferred brand name drugs and possibly generics, both of which are more cost effective. Once a generic medication is released, the brand name counterpart becomes a non-formulary medication.

As new medications receive FDA approval and are released, they are reviewed by the AdvancedPCS Pharmacy and Therapeutics committee (P&T). The P&T Committee makes a recommendation to the Arkansas State and Public School's Drug Utilization and Evaluation Committee (DUEC). The decision to add or not to add a medication to the formulary is first and foremost based upon efficacy.

If there is not another alternative or the medication is superior to the current formulary alternative, then the medication is added. If it is found to be equivalent to current formulary alternatives, then a cost analysis is completed and determination is made. Medications may be deleted from the formulary on a quarterly basis (four times per year) with additions occurring throughout the year. The exception to this rule is when generics become available. Copies of the Arkansas State and Public School Employee's Formulary Preferred Drug List may be obtained by contacting EBD at 1-501-682-9656 or 1-877-815-1017. This list is subject to change.

In the traditional retail program co-payments for each type retail prescription are:

Generic	$10
Formulary Brand Name Drug (Preferred)	$25
Non Formulary Brand Name Drug (Non-Preferred)	$50

The minimum co-payment for any Non-Formulary Brand Name Drug is the lesser of $50 or the cost of the prescription.

Traditionally, each retail prescription is limited to a 34-day supply. Prescriptions are dispensed according to the instructions of the prescribing physician. However, if the medical condition is such that the prescription drug is to be taken over a prolonged period of time (months or even years) it may be more beneficial to use the enhanced retail program or the mail order prescription program described below.

If a prescription is filled at an out-of-network pharmacy the participant will be responsible for paying 100% of the cost when the medication is dispensed plus $1.25 fee for processing a paper claim.

The amount paid to purchase prescription drugs cannot be used to satisfy any annual deductible or out-of-pocket maximum under the medical plans.

Fourth Tier Benefit

This benefit is designed to cover medications, which were not previously covered by the plan such as medications for weight loss and smoking cessation. This benefit gives you access to the same discount the plan pays to network pharmacies. You will be responsible for the entire cost of the drug at the discounted rate.

Example:

Drug prescribed for weight loss	Retail Cost	$150.00
	Average Wholesale Price	$130.00
	Plan Discount 13%	$113.10
	Dispensing Fee	$2.50
	You Pay	$115.60

This example shows a savings of $34.40 from the retail cost you would have paid without this benefit. Simply give your pharmacist your prescription drug card as you always do and the amount you owe will be indicated to the pharmacist via electronic claims submission

Enhanced Retail and Mail Order Program

Members may obtain a 90 day supply of medications at their retail pharmacy or mail order for three (3) copayments. Prior to using this benefit, you must follow these guidelines:

1.You will need to obtain two thirty (30) day supplies of medication or two fills at your participating pharmacy. This helps to ensure that prescriptions are appropriate for the duration of therapy. Please remember to keep your receipts or other proof of purchase.

2. If medication is still required after the two thirty (30) day supplies or two fills, ask your doctor to write a prescription for up to a 90 day supply (if appropriate) with as many as three (3) refills.

Please remember that some medications are excluded from this benefit. A complete list of excluded

medications included in the section below.

Your copayment for a 90 day supply is equivalent to three (3) standard copayments based on the formulary status of the drug. Please refer to the following schedule:

Generic alternative	3X retail copayments of $10 = $30
Preferred drug	3X retail copayments of $25 = $75
Non-preferred drug	3X retail copayments of $50 = $150

Arkansas State Employees and Public School Employees Ninety (90) Day Refill Exclusion List/Drug Class Description	Few examples of drugs in each class, but NOT limited to these drugs
Anti-Infective	All antibiotics, Lamisil, Quinine, Urised
Anti-Viral	Famvir, Valtrex, Norvir, Ziagen
Blood Products	Neupogen, Epogen, Procrit
Anti-Anxiety	Diazepam, Lorazepam, Xanax
Anti-Depressants	Zoloft, Paxil, Amitriptyline
Psychiatric Agents	Methylphenidate, Adderall, Risperdal, Lithium, Lithobid
Sleeping Aids	Halcion, Sonata, Ambien
Muscle Relaxants	Cyclobenzaprine, Skelaxin
Pain Medications	Vioxx, Celebrex, Ibuprofen, OxyContin, Ms Contin, Hydrocodone, Lidoderm
Stomach Medications	Prilosec, Nexium, Protonix
Cough and Cold Products	Novahistine, Phenergan, Entex
Anti-Nausea Medications	Zofran, Kytril
Migraine Headache Products	Amerge, Imitrex, Zomig
Anti-Convulsants / Barbiturates	Phenobarbital, Pemoline
Central Nervous System Medications	Sinemet, Requip, Comtan
Specific Individual Drugs	Accutane, Arava, Lupron, Regitine, Retin A , Avita

Covered Prescription Drugs and Supplies:

- Drugs prescribed by a physician that require a prescription by federal law unless otherwise excluded.
- Insulin when prescribed by a physician, needles and syringes.
- Diabetic supplies (lancets, test strips) are available without a copayment if a medication for diabetes is purchased at the same time.

Limits to Covered Prescription Drug Benefit:

The covered benefit for any one prescription will be limited to:

- The quantity limits established by the plan
- Refills only up to the time specified by a physician
- Refills up to one year from the date of order by a physician

Special Programs:

AdvancePCS, the Pharmacy Benefits Manager for the Arkansas State and Public School Employees, has several cost saving initiatives in place designed to assist our prescription drug program in delivering the best possible healthcare at the most reasonable cost. The programs described below

are Prior Authorization, Quantity versus Time (QVT), Daily Dose Edits, Step Therapy and Special RX.

If a member attempts to fill a prescription for a medication under one of these programs but does not meet the established criteria, the claim will be denied and the member will be responsible for the entire cost of the drug.

Prior Authorization (PA):

The Prior Authorization program helps to ensure the appropriate usage of certain medications by applying FDA approved indications and the manufacturer's guidelines to the utilization of certain medications. Advance PCS has identified the medications that have a high potential for serious side effects, high costs, or high abuse potential.

The following steps should be taken in order to obtain a Prior Authorization:

- Your physician may call Advance PCS at 1-800-294-5979 to obtain a prior authorization form. The form will be faxed to your physician's office.
- Once the physician completes the form, he should fax it back to Advance PCS. A team of pharmacists and pharmacy technicians will evaluate the information provided by your physician.
- Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system.
- If the clinical guidelines are **not** met, your physician will be sent a denial form.
- If the prior authorization is denied, you can still get your prescription but you will be financially responsible for the full charge of the prescription.
- Your physician may appeal the denial. The instructions to appeal the denied prior authorization request are included with the denial form.
  (The appeal process outlined on page C-8.)

Drugs Requiring Prior-Authorization

Drug Name	Usage (TX = Treatment)
Lamisil	TX of toe & fingernail fungus
Sporanox	TX of toe & fingernail fungus
Lidoderm patch	Tx of pain associated with post-herpetic neuralgia
Rebetron 1200	Tx of hepatitis
Rebetron 1000	Tx of hepatitis
Intron A, Infergen, Peg-Intron	Tx of hepatitis
Wellbutrin SR	Tx of depression
Procrit	Stimulate production of red blood cells
Epogen	Stimulate production of red blood cells
Genotropin	Human Growth Hormone
Humatrope	Human Growth Hormone
Serostim	Human Growth Hormone
Norditropin	Human Growth Hormone
Saizen	Human Growth Hormone
Enbrel	Anti-inflammatory
Arava	Anti-inflammatory
Viagra, Muse, Caverject, Edex Papverine	Impotence
Retina-A , Accutane, Avita	Actinic keratoses
Lupion	Endometriosis
Roteron A	Hepatitis C, Leukemia
Synagis	RSV
Remicade	Anti-inflamatory

AdvancePCS Specialty Rx Services:

AdvancePCS Specialty Rx Services is contracted to provide specialty medications to our members. These specialty medications are high cost self-administered injectable medications that are generally biotechnological in nature and usually require special handling and patient counseling. **Members requiring these medications must use AdvancedPCS Speciality RX Services.** For your convenience, we have included a list of the medications provided by AdvancePCS Specialty Rx. This list is current as of October 01 2003. Please call AdvancePCS Speciality Rx at 1-866-295-2779 with questions on this service.

Out of state Speciality Pharmacies no longer qualify for reimbursement.
Members using an out of state Speciality Pharmacy will have total financial responsibility for speciality medications.

Medications Available Through AdvancePCS Speciality RX

Actimmune	Cetrotide	Gonal-F	Leukine	Pergonal	Roferon-A
Alferon N	Copaxone	Helixate	Lovenox	Polygam S/D	Saizen
Alphanate	Cytogam	Hemofil-M	Lupron	Pregnyl	Sandostatin
AlphaNine SE	DDAVP	Humate-P	Lupron Depot	Procrit	Sandostatin Lar
Antagon	Enbrel	Humatrope	Monarc-M	Profasi	Serostim
Apligraf Disk	Epogen	Humegon	Monoclate-P	Profilnine SD	Synagis
Aranesp	Fertinex	Hylagan	Mononine	Proplex T	Temodar
Arixtra	Flolan	Hyate-C	Neupogen	Protropin	Thalomid
Aurolatae	Follistim	Infergen	Norditropin	Pumozyme	Thyrogen
Autoplex T	Fragmin	Immune Globulin	Novatrone	Rebetrol	TOBI
Avonex	Gamimune	Innohep	Novarel	Rebetron	Venoglobulin-I
Baygam	Gammar IV	Intron A	Novoseven	Rebif	Venoglobulin-S
Benefix	Gammar-P IV	Iveegam	Nutropin AQ	Recombinate	Visudyne
Betaseron	Gammagard S/D	Kineret	Ovidrel	Refacto	Vitravene
Bioclate	Genotropin	Kolate-DVI	Panglobulin	Remicade	Xeloda
Ceredase	Geref	Kogenate	Peg-Intron	Repronex	
Cerezyme	Gleevec	Konyne 80	Pegfrilgrastim	Respigam	

Quantity Vs Time Limits:

The QVT list is intended to clarify the usual quantity that constitutes a 34-day supply for these particular medications. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer.

Drug	Quantity limit per 34 days
Impotency Medications (PA required)	
Caverject injection	6
Muse suppositories	6
Viagra tablets	6
Edex injection	6
Asthma Inhalers	
Albuterol,	4

Migraine Medications	
Migranal spray	1 box (4 vials)
Amerge, Imitrex tablets	9
Maxalt	6
Imitrex spray	1 box (6 vials)
Imitrex injection	4
Imitrex kit	2
Frova	9
Axert	6
Zomig 5mg	3
Zomig 2.5 mg	6
Relpax	6
Multiple Sclerosis	
Betaseron	15 vials
Avonex	4 vials
Copaxone	32 vials
Influenza Therapies	
Relenza	20
Tamiflu	10
Miscellaneous	
Zithromax	6
Lamisil	30 per fill, 84 per year
Diflucan 150 mg	1 per fill
Zelnorm	12 wks annually (female only)

Daily Dosing Edits

Daily Dose Edits are designed to notify members when they are taking lower strength medications multiple times a day when higher strengths are available.

Brand Name	Strength Description	Recommended Strength	Secondary Message
Actos	15Mg	30Mg	Use one 30mg
Celexa	20Mg	40Mg	Use one 40mg
Effexor	37.5Mg	75Mg xr	Use one 75mg xr
Effexor xr	75Mg	150Mgxr	Use one 150mg xr
Lescol	20Mg	40Mg	Use one 40mg
Lescol	40Mg	80Mg xl	Use one 80mg xl
Lipitor	10Mg	20Mg	Use one 20mg
Lipitor	20Mg	40Mg	Use one 40mg
Lipitor	40Mg	80Mg	Use one 80mg
Paxil	10Mg	20Mg	Use one 20mg
Paxil	20Mg	40Mg	Use one 40mg
Pravachol	10Mg	20Mg	Use one 20mg
Pravachol	20Mg	40Mg	Use one 40mg
Prozac	10Mg	20Mg	Use one 20mg
Vioxx	12.5Mg	25Mg	Use one 25mg
Vioxx	25Mg	50Mg*	Use one 50mg
Zocor	10Mg	20Mg	Use one 20mg
Zocor	20Mg	40Mg	Use one 40mg
Zocor	40Mg	80Mg	Use one 80mg

Step Therapy:

"Step-therapy" is a treatment approach in which more traditional and less expensive medications are encouraged before graduation to newer, more expensive, and more sophisticated medicines. For example, under step-therapy, a person with a new prescription for a Cox 2 Inhibitor would—if deemed an inappropriate candidate for this form of treatment—be denied the prescription and the member encouraged to try a generic substitute (such as prescription strength Motrin or Naprosyn). That person would then have the option of having his or her doctor call for a prior authorization, or purchasing the Cox 2 Inhibitor at the full price without the pharmacy benefit.

Drug Name	Drug Class
Vioxx, Celebrex, Bextra	Cox 2 Inhibitors

Specific Covered Medications:

Legend Vitamins
Prenatal Vitamins in solution - limited to 50cc per fill
Insulin - standard days limit
All syringes
Blood Glucose and Urine Strips
Blood testing tapes
Blood testing tablets
Lancets
*If insulin or an oral diabetic is in member's history within the last 2 days from the submit date, then all diabetic supplies will pay with a zero co-pay. The pharmacy must submit the insulin or oral diabetic before submitting the supplies or the system will not be able to verify that they are using those medications and it will assess a co-pay.

Excluded Prescription Drugs:

- Over the Counter products that may be bought without a written prescription or their equivalents. This does not apply to injectable insulin, insulin syringes and needles and diabetic supplies, which are specifically included.
- Devices of any type even though such devices may require a prescription. This includes (but not limited to) therapeutic devices or appliances such as implantable insulin pumps and ancillary pump products.
- Immunization agents, biological serum, vaccines.
- Implantable time-released medications.
- Experimental or investigational drugs or drugs prescribed for experimental, Non-FDA approved, indications.
- Drugs approved by the FDA for cosmetic use only.
- Compound chemical ingredients or combination of federal legend drugs in a Non FDA approved dosage form.
- Fertility medications
- Nutritional supplements except for metabolic conditions only.
- Smoking cessation medications
- Weight loss medications
- Ostomy Supplies are no longer covered under the Prescription Drug Program but are covered under the Medical Plans.

Member Appeals Process:

Level 1
Member may appeal any claim denial to AdvancePCS within 180 days of denial. AdvancePCS will review appeal request and provide a written response to the member within 30 days of written request.

Level 2
Member may appeal this decision to the office of Employee Benefits Division within 180 days of initial response. EBD in concurrence with the EBD Physician Advisor will meet to discuss and provide a written response to the member within 30 days of receipt of the Level 2 appeal.

I**f you have questions** about the retail drug program, the mail order program or your prescription order, please call AdvancePCS toll free at 1-877-456-9586. The AdvancePCS customer service hours are:

Monday through Friday:	24 hours a day
Saturday:	9:00 AM to 8:00 PM Eastern Time
Sunday:	9:00 AM to 6:00 PM Eastern Time

Coverage under this plan will terminate on the date a participant is no longer enrolled in a covered Arkansas State and Public School medical plan option.

The Arkansas State and Public School Health and Life Insurance Board reserves the right to amend or modify the plan at any time by actions of its officers.

Attachment B

Mental Health & Substance Abuse Benefit Coverage

Corphealth, Inc., in cooperation with the policy issued by Employers Health Insurance Company, combines the cost savings incentives with freedom of choice. When you see participating providers, you receive services at a discounted level. At the same time, you retain the flexibility to see any qualified, licensed mental health practitioner statewide.

In addition, the Employee Assistance Program (EAP) is a benefit provided to enrollees of this plan.

Arkansas Public School Employees

www.corphealth.com

Arkansas Helpline 1-866-378-1645 (toll free)

Arkansas Public School Employees Mental and Behavioral Health Benefits

If you chose to participate in any of the medical health plans, you automatically receive the Corphealth Employee Assistance Program (EAP) as well as the Mental Health and Substance Abuse (MHSA) Benefit Program. Corphealth coordinates all behavioral health care for Arkansas Public School Health Care enrollees. This benefit program and network of mental healthcare providers is completely separate from your medical plan, regardless of the medical plan you select.

Accessing your Mental Health, Substance Abuse and Employee Assistance Benefits is easy.

You MUST access your behavioral health care benefit by calling the Arkansas Helpline at 1-866-378-1645.

The Helpline is available 24 hours a day, 365 days a year. When you call the Helpline you will:

- Have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Obtain pre-certification for mental health, substance abuse treatment, or EAP services
- Receive individualized referrals to behavioral health resources in your community
- Receive telephonic and/or face-to-face EAP sessions with one of the EAP affiliate counselors

You can maximize your behavioral health benefit by:

Using a Corphealth network provider for Managed Care Services

Using a Corphealth EAP affiliate for EAP services

Pre-certifying all services through the Arkansas Helpline at 1-866-378-1645

The mental health and substance abuse benefits available under this Policy are distinct from the Major Medical Plans. This document is an outline of the insurance provided by the group Policy and it does not extend or change the coverage afforded by such group Policy. The coverage describe here is subject to all the provisions, terms, exclusions and conditions of the Employers Health Insurance Company group Policy. The provisions of this Policy are administered by Corphealth, Inc., and use the Corphealth Provider Network. Corphealth is the designated agent and administrator for this plan. Questions regarding your Mental Health, Substance Abuse and Employee Assistance Program Benefits should be directed to Corphealth at 1-866-378-1645.

Schedule of Benefits

Benefit Description	PPO Network Provider	Out-of-Network Provider
Employee Assistance Program (EAP) Telephonic consultation and face-to-face short term/brief issue resolution counseling	Up to eight (8) EAP sessions per episode with no Co-Payment.	Not Covered
Behavioral Health Annual Maximum Out-of-Pocket - Individual - Family	 $1,500 $3,000	 $1,850 $3,750
Maximum Lifetime Benefit	$1,000,000	$25,000
Inpatient Services	$500 copay + 20% coinsurance/ admit	$625 copay + 45% coinsurance
Outpatient Services – Traditional	$35 copay/visit	$35 copay + 25% coinsurance
Partial Hospital/Day Treatment	$100 copay first visit +20% coinsurance	$125 copay first visit +45% coinsurance
Outpatient Services – Intensive	$100 copay first visit +20% coinsurance	$125 copay first visit +45% coinsurance
Residential Treatment	20% coinsurance	45% coinsurance

Preferred Provider Network

The Preferred Provider Network consists of mental health and substance abuse providers designated by Corphealth including Hospitals, Qualified Treatment Facilities, Qualified Practitioners, and other providers, which have entered into agreements. Benefits are typically paid at the higher benefit levels (coinsurance, maximum lifetime benefit, co-pay) if Services are provided by a Preferred Network

Provider. Preferred Providers are paid directly by Corphealth, except for your copay and coinsurance. You may get help finding an appropriate Preferred Network Provider by calling the Arkansas State Employee Helpline, 1-866-378-1645, or visiting the Corphealth website (www.corphealth.com).

Preauthorization/Precertification Requirement

If Preauthorization is not obtained, benefits under this Policy will be denied and you will be responsible for payment. When you or your designee calls for preauthorization, Corphealth will:

- Advise you if the proposed treatment plan is a covered expense;
- Provide you with a certification number; and
- Continue to review services throughout the course of your covered service.

Pre-certification is not a guarantee of payment. Payment determinations are made at the time claims are submitted. All payments are subject to policy guidelines, medical necessity, and member eligibility at the time services are performed.

- Anasthesia services for Electro Convulsant Therapy is only covered when provided at a Bridgeway facility and requires pre-authorization.

We must be notified within twenty-four (24) hours after your confinement or Emergency Care.

Maximum Allowable Fees for Non-Network Providers

The Maximum Allowable Fee for services provided by Non-Network Providers is based on the fee negotiated with Network Providers within the Service Area. You are responsible for 100% of charges in excess of such maximum allowable fee. Such excess amounts are not considered Covered Expenses and will not apply to the Deductible or the Out-of-Pocket Limits.

Covered Expenses

Covered Expense means an expense for a Medically or Psychologically Necessary Service as described in the Policy and Certificate of Insurance. Covered Services include Covered Expenses for Mental Disorders and incidents of Substance Abuse furnished as Outpatient Services, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Inpatient Services. Covered Services must be performed by Qualified Practitioners and Qualified Treatment Facilities.

Emergency care

Emergency care means services provided for a Mental Disorder or an incident of Substance Abuse manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to:

- result in placing the health of that individual in serious jeopardy;
- serious impairment of bodily functions;
- or serious dysfunction of any bodily organ or part.

Corphealth must be notified within twenty-four (24) hours after your confinement for Emergency Care.

Medically Necessary

Medically Necessary means appropriate and essential for the purpose of diagnosing, palliating or treating a Mental Disorder or Substance Abuse condition, or its symptoms. Such Services and associated treatments or products must be:

- In accordance with nationally recognized standards of medical practice and generally accepted as safe, widely used and effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician, or other health care provider,
- Clearly substantiated by the medical records and documentation concerning the patient's condition;
- Performed in the least restrictive setting required by the patient's condition
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in peer reviewed literature in English as of the date of Service; and
- Not expressly excluded under this Policy.

Psychologically Necessary

Psychologically Necessary means appropriate and essential for the diagnosis, evaluation and/or treatment of a Mental Disorder or Substance Abuse condition. Such Services and associated treatments or products must be:

- In accordance with nationally recognized standards of mental health professional practice and generally accepted as safe, widely used and effective for the proposed use;
- Supported by the preponderance of nationally recognized peer review medical and mental health professional literature, if any, published in peer reviewed literature in English as of the date of Service;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician, or other health care provider;
- Clearly substantiated by the medical records and documentation concerning the patient's condition;
- Performed in the least restrictive setting required by the patient's condition; and
- Not expressly excluded under the Policy.

Limitations and Exclusions

Your group may have specific limitations and exclusions not included in this list. Please check your Group Policy/Certificate of Insurance for the complete listing. The Group Policy/ Certificate of Insurance is the document upon which benefit payment will be determined.

1. Any non-Emergency Care received without Preauthorization;
2. Services not Medically Necessary or Psychologically Necessary for diagnosis or treatment of a Mental Disorder or Substance Abuse condition;
3. Inpatient Services when You are in Observation Status;
4. Any Service which is Experimental, or for Research Purposes;
5. Services:
   - (a) Not furnished by a Qualified Practitioner or Qualified Treatment Facility;
   - (b) Not authorized or prescribed by a Qualified Practitioner;
   - (c) For sexual or gender identity disorders;
   - (d) Beyond those necessary for the diagnosis of mental retardation, pervasive development disorders (including autism) disruptive behavior disorders (including conduct disorder and oppositional defiant disorder).
   - (e) For pain with physiological origins unless We determine such pain has psychological or psychosomatic components;
   - (f) Provided in connection with, or to comply with, involuntary commitments, police detentions and other similar arrangements, unless authorized by Us as Medically Necessary or Psychologically Necessary;
   - (g) For Methadone treatment, LAAM, Cyclazine or equivalents;
   - (h) For sexual dysfunction including sex therapy;
   - (i) For any Mental Disorder or Substance Abuse condition related to disorders, disabilities or

addictions designated in diagnostic categories of the Diagnostic and Statistical Manual IV of the American Psychiatric Association defined by EDP;

(j) For which no charge is made, or for which You would not be required to pay if You did not have this insurance, unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;

(k) Furnished while You are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected condition;

(l) Which are not rendered or not substantiated in the medical records;

(m) That are not listed as a Covered Expense;

(n) Provided by a person who ordinarily resides in your home or who is a Dependent;

(o) That are performed in association with a Service that is not covered under the Policy;

(p) That are billed incorrectly or billed separately, but are an integral part of another billed Service, as determined by Corphealth.

6. Charges in excess of the Maximum Allowable Fee for the Service;
7. Pre-Existing Conditions to the extent specified in the Certificate and on the Schedule of Benefits;
8. Any Expense Incurred before the Effective Date under the Policy;
9. Any Expense Incurred after the date Your coverage under the Policy terminates;
10. Any Expense Incurred exceeding the Lifetime Maximum Benefit under the Policy;
11. Custodial Care and Maintenance Care;
12. Any prescription or over-the-counter drug, medication or biological;
13. Vitamins, dietaries, and any other non-prescription supplements;
14. Services for which there is payment or expense coverage provided or payable under any Major Medical Plan, other health insurance coverage, self insurance coverage, automobile, homeowners, premises, or any other similar coverage;
15. Any loss contributed to, or caused, by (a) War or any act of war, whether declared or not; or (b) Any act of armed conflict, or any conflict involving armed forces of any authority;
16. The treatment of Mental Disorder or Substance Abuse condition unless specifically provided in the Mental Health Covered Services provision of the Certificate and shown on the Schedule of Benefits - Mental Health;
17. Private duty nursing;
18. Loss due to commission or attempt to commit a civil or criminal battery or felony;
19. Services rendered by a standby physician or assistant surgeon, unless Medically Necessary;
20. Treatment of obesity;
21. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes;
22. Educational or vocational therapy, services and schools, including, but not limited to, videos and books;
23. Communications or travel time;
24. Lodging accommodations or transportation, except as specified in the Certificate;
25. Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician);
26. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
27. Any charges, including Qualified Practitioner charges, which are incurred if You are admitted to a Hospital or Qualified Treatment Facility on a Friday or Saturday unless (a) Your Confinement is due to Emergency Care; or (b) Treatment or therapy is performed on that same day;
28. Alternative Medicine;
29. Marital counseling;
30. Treatment of any Mental Disorder, incident of Substance Abuse or other conditions that arises from, or is sustained in the course of, any occupation or employment for compensation, profit or gain; or

31. Any Service ordered by a court or government agency, which is not determined by Corphealth to be Medically Necessary or Psychologically Necessary.

Summary: All services require precertification for all levels of care (including EAP).

EAP Distinction:

The Arkansas STAR Employee Assistance Program (EAP) is a program of mental health and substance services offered to Employees and Dependents at no charge. All services are rendered by EAP counselors and include assessment, counseling, and issue resolution. The Arkansas STAR EAP is designed to help you resolve short-term problems related to family marital and peer relationships, parenting, finances, school, elder care, etc. The following conditions apply to the EAP:

- Medical necessity is not required, however, pre-authorization must be obtained
- All EAP services must be provided by a Corphealth approved EAP affiliate
- Sessions are limited to eight per episode
- Psychological Testing, any facility based care, or services rendered by a psychiatrist are not covered under the EAP

Attachment C
Life Insurance Options for Arkansas Public School Group Employees

Basic Life and AD&D:

$5,000.

All new employees who participate in the school health insurance plan automatically receive $5,000 in basic life and AD&D insurance benefits. Monthly Premium: $0.65.

Supplemental Life and AD&D:

Classification By Basic Annual Earnings	Insurance Amount	Monthly Premium
$10,000 or less	$20,000	$ 5.00
$10,001 - $15,000	$30,000	$ 7.50
$15,001 - $20,000	$40,000	$10.00
$20,001 - $25,000	$50,000	$12.50
$25,001 - $30,000	$60,000	$15.00
$30,001 and above	$70,000	$17.50

Dependent Life:

Coverage Amount	Monthly Premium
$2,500	$1.20

Basic Life/AD&D

1) All new employees who participate in the school health insurance plan automatically receive $5,000 in basic life insurance benefits. These new employees are enrolled in the life when the health application is completed.

2) The basic $5,000 life insurance is packaged with the health premium and is billed on the health insurance bill provided by EBD, regardless of which school health plan is chosen. Premiums for this coverage are payroll deducted from the employee's paycheck.

3) Beneficiary designations for the $5,000 Basic Life/AD&D need to be made using USAble Life form APSGAPP 7-02 and completing the orange areas. This is the same form that is used to apply for Supplemental Life. It is very important that employees complete this form to ensure insurance proceeds are paid appropriately should a claim occur.

4) Please keep a copy of this form for your records and provide a copy and the original to the School Business Official. The original will be submitted to USAble Life.

5) Please request from your School Business Official a new Basic and/or Supplemental Life insurance booklet.

Supplemental Life/AD&D and Dependent Life

1) Employees should use USAble Life form APSGAPP 7-02 to apply for Supplemental Life/Dependent Life and designate their beneficiary.

2) All full-time employees, regardless if they participate in the school health insurance plans or not, are eligible to participate in the USAble Life Supplemental Life/AD&D and Dependent Life insurance program.

3) New hires after October 1 each year are eligible for Supplemental Life/AD&D and Dependent Life insurance guaranteed issue as long as they apply within 31 days of their hire date. All areas of the application should be completed, with the exception of medical questions.

4) Employees who are not new hires and would now like to apply for the Supplemental Life/AD&D and/or Dependent Life program may do so. They must complete all areas of the application, including medical questions, as they will be medically underwritten for the Supplemental Life/AD&D and/or Dependent Life. Premiums for this coverage are payroll deducted from the employee's paycheck.

5) Please keep a copy of this form for your records and provide a copy and the original to the School Business Official. The original will be submitted to USAble Life.

6) Your School Business Official will be notified if your applicantion is declined.

7) Please request from your School Business Official a new Basic and/or Supplemental Life insurance booklet.

Benefits for Retirees

Basic and Supplemental Life Insurance: The amount of Basic and Supplemental Life Insurance will be reduced by fifty percent (50%) on the date of an employee's retirement provided they become an annuitant under the Teachers' Retirement System, and they participate in the health benefit plan for retirees. If they do not meet both of these requirements, their Basic and Supplemental Life insurance will terminate on the date of their retirement. In order to retain life insurance coverage at retirement, the employee must complete form #APSG-RET (7-01), and remit it to USAble Life. Premiums for this coverage are deducted from the employee's annuity check. In the event the annuity check is not sufficient to deduct the premiums, USAble Life will bill for the premiums directly to the retired employee's home address.

Accidental Death and Dismemberment Insurance - Basic and Supplemental AD&D coverage will terminate on the date of retirement.

Dependent Life Insurance: Dependent Life coverage will terminate on the date of retirement.

The USAble Life Customer Service department is available to answer questions regarding the Basic Life/AD&D; Supplemental Life/AD&D and Dependent Life for school employees. Our dedicated toll-free number for school districts is:

1-800-370-5854
Email: custserv@usablelife.com

Contact Page

HEALTH INSURANCE AND PRESCRIPTION COVERAGE

Advance PCS, Inc.
1300 East Campbell
Richardson, TX 75081
Customer Service.....(877) 456-9586
Web site……>http://ar.advancerx.com

Arkansas Blue Cross & Blue Shield
P. O. Box 2181
Little Rock, AR 72203
Toll-Free.....(800) 482-8416
Local Office.....(501) 378-2437
E-mail.....stateemployees@arkbluecross.com
Web site address:.....www.arkbluecross.com

Health Advantage
P. O. Box 8069
Little Rock, AR 72203
Toll-Free.....(800) 482-8416
Local Office.....(501) 378-2437
E-mail.....stateemployees@arkbluecross.com
Web site address:..www.healthadvantage-hmo.com

QualChoice/QCA
10525 Financial Centre Parkway, Suite 400
Little Rock, AR 72211
Toll-Free.....(800) 782-5246
Local Office.....(501) 228-7111
E-mail.....www.qcark.com
Web site address:.....www.qcark.com

LIFE INSURANCE

USAble Life
320 West Capitol, Suite 700
P.O. Box 1650
Little Rock, AR 72203
Toll-Free Customer Service.....(800) 370-5856
Toll-Free Life Claims.....(800) 648-0271
ILocal Office.....(501) 375-7200

BEHAVIORAL HEALTH

CORPHEALTH/STAR EAP
1701 Centerview Dr., Suite 101,
Little Rock, AR 72211
1-866-378-1645
Web site:…….....www.corphealth.com

Employee Benefits Division
P.O. Box 15610
Little Rock, AR 72231-5610
Toll-Free.....(877) 815-1017
Local Office.....(501) 682-9656
EBD Privacy Officer.....(501) 682-9656
Web site addresses for:
Examples, Current Policy, Policy Changes
www.accessarkansas.org/dfa/ebd

Email address for Benefit Questions:
askebd@dfa.state.ar.us

Community Resources

Easter Seals Arkansas
3920 Woodland Heights Road
Little Rock, AR 72212-2495
Phone: (501) 227-3600

Arkansas Spinal Cord Commission
1501 North University, Suite 400
Little Rock, AR 72207
(501) 296-1792

American Red Cross
401 S. Monroe
Little Rock, AR 72205
(501) 614-4410

Arkansas School for the Blind
2600 W. Markham
Little Rock, AR
(501) 296-1810

Arkansas School for the Deaf
2400 W. Markham
Little Rock, AR 72205
(50) 324-9506

American Heart Association
909 W 2nd Street
Little Rock, AR 72201
(501) 375-9148

American Cancer Society
901 N University Ave
Little Rock, AR
1-800-227-2345

American Lung Association
211 Natural Resources Drive
Little Rock, AR 72205
(501) 224-5864

American Diabetes Association
212 Natural Resources Drive
Little Rock, AR 72205
(501) 221-7444